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ORIGINAL LECTURES.

A COURSE OF LECTURES ON DERMATOLOGY.

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(Reported by Henry Wile, M.D.)

LECTURE VII.

SYPHILODERMA; LEPRA; FRAMBŒSIA; PELLAGRA; EPITHELIAL CANCER; SARCOMA; LYMPHANGIOMA; MYOMA; DERMATALGIA; PRURITUS.

SYPHILIS OF THE SKIN, or syphilis cutanea, includes the various manifestations upon the skin due to syphilis. The syphilodermata occur in a manifold variety of lesions, in more numerous forms even than eczema, and the statement of some authorities, that there is scarcely any form of cutaneous lesion which syphilis may not assume, is suggestive.

General symptoms are, as a rule, absent, though slight fever, malaise and languor are sometimes met with. Other symptoms usually concomitant, are enlargement of the lymphatic glands, angina, alopecia and the occurrence of mucous patches. Syphilis attacks no particular region, although the different forms of eruption show preference for certain localities. Symmetry is a characteristic of the earlier eruptions; irregularity in distribution of the later forms.

The lesions of cutaneous syphilis are noted for their multiformity, almost all of the forms common to other cutaneous diseases being liable to appear, the papule and pustule, however, being the most frequent. Polymorphism is commoner in the earlier than in the later eruptions. The configuration is also peculiar, the earlier lesions being rounded, while the later assume an annular, crescentic or serpiginous form. The color varies with the age, complexion, and stage of the disease. Early lesions are first of a pinkish or dull-reddish hue, usually passing through varied tints to a violaceous, coppery or brownish-red color. Older lesions, especially papules and tubercles, often have a deep-red, cold, non-inflammatory look.

The course of the disease is usually slow; especially is this the case with the later forms. Relapses are common. Subjective symptoms are, as a rule, absent; pain is, however, sometimes present with ulcerative lesions. Itching occasionally accompanies the small papular and pustular syphilodermata.

Syphiloderma erythematosum, or macular syphiloderm, consists of rounded or ovoidal macules, pea- to finger-nail-sized, ill-defined, faint or marked, bright or dull pinkish or violaceous, often presenting a mottled or marbled appearance. Later, the lesions grow darker, assuming a dirty-yellowish, dusky-brownish or coppery color, and then disappear. They are generally numerous, and appear first upon the trunk, abdomen and thorax, then upon the flexor surfaces of the limbs, and sometimes upon the face. The eruption has no regular distribution. It is the earliest syphiloderm, and appears in from six to ten weeks after the initial lesion, with or without malaise or other general symptoms or signs of syphilis. Its development is, as a rule, slow, requiring one to two weeks, though it may be rapid, coming out over night or after a hot bath. Its duration varies from a few weeks to several months. It must be distinguished from measles, rötheln, urticaria, and medicinal eruptions—as from quinine and copaiba; also from tinea versicolor.

Syphiloderma papulosum is an eruption in which the lesions vary in size and shape, generally being the size of a millet-seed, pea or small bean, acuminate or flat, discrete or confluent. On account of this variation in size, the division into the small and large papular syphiloderm is proper, by which cases can be more easily and precisely classified.

The *small papular syphiloderm*, also called the miliary papular syphiloderm, occurs in the form of millet-seed sized, rounded or acuminate, generally profuse lesions, which are elevated, firm or solid, disseminated or grouped, and of a bright or dull red color. The eruption is usually well marked; occurring as an acute process it may appear in a few days. It may be an early or a late manifestation, showing itself at any time between the second and twelfth month; when late, it is generally in conjunction with the large papular syphiloderm. It is mostly seen on the trunk, upper extremities and thighs, and is more common in debilitated subjects and in women than in men, and runs a chronic course, leaving pigment stains. In the matter of diagnosis, it is to be distinguished from keratosis pilaris, from papular eczema, and from psoriasis punctata.

The *large papular syphiloderm*, also called the lenticular papular syphiloderm, consists of pea to bean-sized flat, rounded or ovoidal, elevated, firm and circumscribed, pale or dull red lesions. They are usually profuse and are found more abundantly in certain localities, as on the forehead, nape of the neck, back, and flexor surfaces of the extremities. It is one of the commonest of the syphilitic eruptions, and is an early manifestation, closely following the erythema, and is often rebellious to treatment. Location influences these lesions and effects certain modifications in them. When arising on the mucous membrane of the mouth or in the axilla, groin, about the genitalia or beneath the mammæ in women, where the skin on account of opposing surfaces is kept moist by excessive perspiration, the epidermis becomes macerated and the lesions are then called *moist papules*, or *flat condylomata*. Sometimes there is an excessive proliferation of the rete cells giving rise to papillary or warty growths—occasioning the *hypertrophic* or *vegetating syphiloderm*. On the other

hand, the papule may undergo the opposite change, giving rise to the *papulo-squamous syphiloderm*, in which the lesions are for the most part grouped, forming patches, and covered with layers of thin, grayish, more or less adherent scales. The regions thus attacked are usually the palms and soles, and the character of the lesions is due to the peculiar anatomy of the skin in those regions, the epidermis being very thick. The eruptions are also known as the *palmar* and *plantar syphiloderms*. They are generally symmetrical, occurring usually in the centre of the palms or soles, the lesions for the most part assuming a crescentic shape with elevated edges. When unilateral, it is generally a late manifestation. It is liable to be mistaken for eczema, psoriasis and callosity, but the history and development of the lesions, together with the shape and sharp definition, are usually sufficient to establish the diagnosis.

Syphiloderma vesiculosum is an exceedingly rare form of cutaneous syphilis, there being but few marked cases on record. The lesions generally resemble those of varicella, and usually appear about the face and genitalia, where the skin is thin.

Syphiloderma pigmentosum (syphilitic chloasma) is very rare in this country, but more common in France. It occurs chiefly upon the neck, mostly of women with delicate, thin skins, and, usually, in the second year after infection. The lesions are pea-sized, and consist of simple, pale-brownish, pigmentary deposits.

Syphiloderma pustulosum constitutes an important class, and is divided into varieties according to the size and general characters of the lesions.

The *small acuminated pustular syphiloderm* is similar in appearance to the miliary papular syphiloderm, except that the lesions are pustules, and may often be an advanced stage of the latter. The lesions consist of small, pin-head sized, rounded or pointed pustules situated on a red elevated base. They are always abundant, occurring as discrete or confluent lesions, forming large groups, circles or crescentic patches. Their favorite seats are the arms, thighs, chest, and back. Sooner or later the puriform contents dry into yellowish crusts, which dropping off are followed by pigmentary stains. This eruption may occur as early as the second or third month, and in this case usually disappears rapidly.

The *large acuminated pustular syphiloderm* may resemble acne very closely, and is sometimes also difficult to distinguish from variola. It is acute or chronic, usually the former, and accompanied by pain, languor and fever. It attacks the face, scalp and trunk, and also the upper extremities and the thighs. It is a somewhat rare manifestation, generally occurs early, and is amenable to treatment.

The *small flat pustular syphiloderm*, or impetigo-form syphiloderm, is also a rare variety, looking not unlike pustular eczema. The pustules occur in patches for the most part upon the face around the nose and mouth; also about the genitalia, the lesions soon rupturing, forming yellowish, greenish or brownish crusts.

The *large flat pustular syphiloderm*, or ecthyma-form syphiloderm, consists of finger-nail sized flat pustules upon a red base, which soon form crusts. There are two varieties, the superficial and deep-seated. In the former the flat, yellowish-brown crusts cover a superficial, freely secreting ulcer, and the lesions generally appear after the sixth month, and mostly upon the back, shoulders and extremities. The deep-seated variety, known as *rupia*, is a late manifestation, and possesses a malignant character. The crusts are thick, stratified, hard, of a greenish or blackish color, and cover a sharply defined, excavated ulcer, secreting a copious, greenish, puriform fluid.

Syphiloderma tuberculosum is usually a late manifestation, and is seen more frequently than any other eruption; occurring one, five, ten or twenty years after the initial lesion. The lesions vary in size from a small to a large pea, or are in the form of flat infiltrations, of a bright or usually dark-red, coppery, smoky hue; single, or more commonly multiple, disseminated, or grouped, or arranged in circles, segments of circles, or serpiginous tracts. The course is slow; they may, for a time, remain without undergoing any change; on the other hand, they may go on to ulceration or absorption. There are usually no subjective symptoms. When in the state of ulceration, papillary or cauliflower growths may spring up from the surface. The tubercular syphiloderm is to be diagnosticated from lupus vulgaris, cancer, and lepra, and the characteristic points to be remembered are the sharp, punched-out nature of the ulcer, its deeply infiltrated and raised border, and relatively rapid development.

Syphiloderma gummatosum, gumma or syphiloma, begins as a small, pea-sized, soft, elastic, colorless or pinkish subcutaneous tumor, growing slowly to the size of a hazel-nut or walnut. It has a tendency in time to break down and ulcerate with great destruction of tissue. Gummata rarely exist in numbers, usually but one or two occur, and most commonly in debilitated individuals, five or ten years after the initial lesion, though exceptionally as early as the first or second year of the disease. It is to be diagnosticated from simple abscess, furuncle, lymphatic gland, cancer, and fibrous and fatty tumor. It heals by absorption, or ulcerates and leaves an insignificant scar compared with the amount of ulceration.

Syphiloderma bullosum, a rare, late manifestation, consisting in the formation of blebs, which generally become puriform, and dry, and form large stratified crusts. Its presence indicates a greatly depressed state of the system.

Syphiloderma hæreditarium infantile.—The child may come into the world apparently healthy or with cutaneous manifestations, the former usually being the case. A month or six weeks after birth, lesions appear, attended with coryza and snuffles, consisting of erythema, maculo-papules, papules, blebs, or a mixture of these, generally occupying the thighs, buttocks, genitals, palms and soles, together with mucous patches. The bullous syphiloderm is, as a rule, present at birth, and consists of variously sized blebs, occurring most frequently about the hands and feet. These lesions soon rupture, and may give rise to ulceration.

The pathology of the syphilitic papule or tubercle shows it to be a neoplasm, composed of small, round, lymphoid cells, packed together, forming an infiltration resembling that of lupus vulgaris. The cell-deposit is most marked around and in the immediate neighborhood of the bloodvessels; it occupies more or less all the layers of skin below the horny layer, and is sharply circumscribed.

Respecting treatment, mercury and iodide of potas-

sium are our most valuable remedies; and with them mainly the disease must be combated. They are administered in varying doses and in various combinations. When used together they constitute what is known as the "mixed treatment." Mercury, when used alone, may be administered by the mouth, by hypodermatic injection, or by inunction; in all cases salivation is to be avoided. The objections to the hypodermatic method, as introduced by Lewin, of Berlin, is that it is painful, and that patients generally object to its employment. Subcutaneous abscesses also often follow, and the procedure consumes too much time for the patient. The administration by the mouth is preferable to that by inunction, in that it avoids the staining of linen, takes up much less time, and, above all, in that the dose can be more accurately given. In the mixed treatment, the formula generally used is as follows:

℞.—Hydrargyri biniodidi, . . . gr. iss.
Potassii iodidi, ... ʒiij.
Syr. sars. co., ... fʒiv.—M.

Sig.—One teaspoonful, with water, thrice daily.

Local treatment of ulcerations may consist in the use of ointments of ammoniated mercury, one-half to one drachm to the ounce of lard; or ointment of the nitrate of mercury, one to two or four drachms to the ounce; or the oleate of mercury ointment, five to twenty per. cent. strength. A mercurial ointment is also valuable, and is almost exclusively used in the hospitals of Vienna.

LEPRA, known also as leprosy and as elephantiasis græcorum, has of late received considerable attention in the journals. The disease in our country occurs not only on the coast of California among the Chinese, but also in Louisiana and in Minnesota, and in other States. It may be defined as an endemic, chronic, malignant, constitutional disease characterized specially by disease of the cutaneous, nerve and bone structures, resulting in anæsthesia, ulceration, necrosis, general atrophy, and deformity. Its invasion is usually slow and insidious, with premonitory symptoms of debility, nervous prostration, languor and the like. Persons sojourning in foreign countries for a time, as English soldiers in India, may thus contract the disease. Sooner or later blebs, macules, and pigmentary or tubercular lesions appear, together with nerve involvement and other symptoms.

Two forms of leprosy are recognized: tubercular and anæsthetic, which, however, may coexist.

Lepra tuberculosa is characterized by masses of infiltrations and tubercles preceded generally by an eruption of blebs, which are often the first manifestation. Macules then appear in the form of smooth, shining, erythematous patches, the condition being known as *lepra maculosa*. The lesions are of a yellowish or brownish color, present a brawny appearance, and usually involve the trunk and extensor surfaces of the extremities. The sensibility of the parts affected is markedly altered, there being first hyperæsthesia, then anæsthesia. The course of this variety is variable, sooner or later tubercles and prominent tumors begin to appear, giving rise to *lepra tuberosa*. The lesions are seated in the skin and subcutaneous tissue, are of a brownish or bronzed color, situated, for the most part, about the face, producing a striking appearance known as *leontiasis*, the features becoming distorted, and the skin thickened, swollen and infiltrated. It may also attack the mucous membrane of the mouth, pharynx, epiglottis, and larynx. Ulceration occurs commonly about the fingers and toes.

Lepra anæsthetica may appear with the tubercular form or alone. Blebs followed by a pigmentary deposit often precede the anæsthesia. Hyperæsthesia may also precede it, attended with pain and burning sensations. The macular patches are generally anæsthetic, so much so that a pin may sometimes be thrust into them without giving rise to pain. The skin and also the deeper structures become atrophied, while the fingers and toes become crooked, bent and mutilated, the ends often dropping off, giving rise to *lepra mutilans*.

The causes are obscure. The disease generally exists endemically, especially in certain countries, as along the shores of the Mediterranean Sea, Atlantic and Indian Oceans, also in Asia Minor, India, China, and in some of the islands of the Pacific Ocean, especially the Sandwich Islands. It is also met with in Norway, Greece, Spain and Sicily; and in Mexico, Central America, West Indies, Brazil, and sporadically in the United States. A case is reported which occurred near New York, the patient never having been outside of his native county, and in which there was no evidence of hereditary taint. As to the contagiousness of the disease authorities stand divided, and strong evidence is brought forward on both sides. It is probable that the disease is contagious in the sense that syphilis is contagious. It is hereditary, being handed down from generation to generation. It is a distinctive disease, and has no relation with syphilis. The cause seems to be intimately connected with climate, soil, food, and habits of the people.

As to its pathology, it is a cellular deposit, like that in lupus and in syphilitic new formations, being most marked around the thickened bloodvessels. It involves the nerves, and thus gives rise to pain and anæsthesia. In the diagnosis it is to be distinguished from lupus, syphilis, scrofula, vitiligo, and morphœa. The premonitory symptoms and constitutional disturbance, together with the history of the case, and the deep-seated pain or anæsthesia, are usually sufficient to mark the disease and to prevent any error in diagnosis. As to treatment, hygiene, change of climate, and regulation of diet are of the utmost importance. Alteratives such as iodide of potassium, quinine, iodine, and cod-liver oil are useful, also gurgun oil, chaulmoogra oil, and Hoang-Nan, the last three being used by the natives, and are supposed by some to exert a good influence upon the disease. Locally baths of sulphur and inunctions with various oils, as gurgun and chaulmoogra, are highly recommended.

FRAMBŒSIA, also called yaws and pian, is an endemic disease of the West Indies, Fiji and other islands, South America, and the coast of Africa. The eruption is accompanied by constitutional febrile symptoms, and is characterized by variously sized reddish papules and tubercles, resembling a strawberry or a currant, which soon ulcerate and break down.

PELLAGRA, or Lombardian leprosy, is an endemic

disease occurring mostly in the northern parts of Italy. The eruption, which is confined chiefly to those parts exposed to the sun, consists of a diffuse inflammatory redness ending in desquamation or the formation of vesicles and bullæ followed by crusts. The disease is accompanied by nervous prostration, melancholia, loss of mental power, and is said to be more common at certain times of the year. It is supposed by some to be caused by the ingestion of a certain ergot of rye or maize.

EPITHELIOMA, epithelial cancer, or cancroid, may manifest itself in one of three varieties—superficial, deep-seated or papillary.

The superficial, known also as the flat variety, usually makes its appearance as one or more yellowish or reddish papular elevations, often starting in a sebaceous gland or wart. Sooner or later it breaks down, oozes, discharging a watery or bloody secretion, and becomes crusted. An ulcer now forms, crusted, and with a variable amount of induration, which later becomes marked and sometimes ring-like around the sore, or later even distinctly everted. The lesion may at first be small, the size of a pea, and later develop to the size of a silver dollar. A chronic form of this variety of cancer is known as *rodent ulcer*, occurring usually about the face, especially the upper half, more particularly the orbital region. It develops slowly, and may last from five to twenty years.

The deep-seated (known also as the infiltrating) variety generally begins as a firm, reddish tubercle in the skin, sometimes involving the subcutaneous tissue. It may start in a wart or nævus, and after a varying period of time, usually months, ulceration sets in. The lesion secretes a yellowish offensive fluid, its edges become infiltrated, and the whole process is attended with destruction of tissue, and frequently pain. The course of this variety of cancer may be slow or rapid.

The papillary variety occurs in the form of a papillary, warty, cauliflower-like growth, and often begins in a wart. The lesions, varying in size from a pea to a dollar, are raised, spongy, soft, dry or moist, crusted or covered with a viscid, sebaceous or bloody secretion. The common site of the disease is the face, especially about the mouth. It usually arises from an irritated point in the tissues, *e. g.*, excoriations from smoking a pipe, warts and nævi. It occurs more frequently in males than in females, and is most common after middle life, between the age of fifty and sixty.

Pathologically, it is an epithelial proliferation of a malignant type, the malignancy being variable. The cell of the new formation is of the squamous epithelial type, and the excessive development of the rete mucosum downwards into the corium in the form of tubular prolongations, gives rise on section to the numerous epithelial nests or pearly bodies, which are characteristic. This epithelial proliferation is accompanied by a subacute inflammatory process by which the tissue of the corium becomes the seat of a small round-cell infiltration, the whole being followed by subsequent degenerative changes. The disease begins in the normal squamous epithelium of the skin or mucous membrane. It is the least malignant variety of cancer.

Epithelioma must be differentiated from syphilitic tubercles and ulcerations, lupus, and common wart. The development of syphilitic lesions is more rapid than cancer, and the secretion in the former is more profuse. The edges of the cancerous lesion are everted, and the surrounding tissue is more or less infiltrated, while in syphilis the induration ends abruptly. In the former there is also pain, which is, as a rule, absent in the latter. To distinguish epithelioma from simple wart, the age of the patient, the mode of growth and course of the disease are necessary to support the diagnosis. From lupus vulgaris it is diagnosticated by it attacking the middle-aged or elderly, by its appearance, and that it occurs generally as a single lesion. Lupus is a disease of childhood and usually invades several parts of the body. The cancerous ulcer secretes a pale or bloody, viscid, often offensive fluid, while the secretion from the lupus ulcer is puriform and inoffensive.

The treatment of this disease consists of complete removal of the growth by means of the knife, curette, caustics or galvano-cautery, or in its destruction by electrolysis; one of these means is to be employed, according to the region, location, and size of the lesion. The superficial variety may in most cases be successfully treated by a thorough application of caustic potash, destroying not only the growth, but the bordering healthy tissue. The pain usually subsides immediately after the application; if not, it can be relieved by bathing the part with dilute acetic acid. After cauterization some mild dressing, as of olive oil, may be used, and in a week or two the blackish eschar will fall off leaving a granulating surface which, in favorable cases, soon heals over leaving a scar. Other caustics, as arsenic with powdered acacia, equal parts, made in the form of a paste, or pyrogallic acid in the form of an ointment, one or two drachms to the ounce, are also useful in some cases. The treatment with the curette, or scraping-spoon, is of great value in the superficial variety, and should precede the use of caustics. In the deep-seated variety the most satisfactory treatment is that by the knife. It is also the best resort when repeated cauterizations have failed to arrest the development of the process. The prognosis should always be guarded, as relapses are common.

SARCOMA of the skin consists of pea- or bean-sized, pigmented or non-pigmented, discrete, smooth, firm and elastic, reddish, violaceous or brownish tumors. The multiple pigmented variety generally occurs on the soles and backs of the feet, then upon the hands, the lesions being of a brownish, bluish or blackish color. It generally proves fatal, usually in a few years. The term *inflammatory fungoid neoplasm* has been used to express a rare form of sarcomatous disease, and occurs in variously sized, flat or oval, smooth or scaly, pale pinkish, reddish or violaceous, tubercular or fungoid tumors. The lesions may develop slowly or rapidly, the process running a variable course, tending to terminate fatally.

LYMPHANGIOMA of the skin is characterized by multiple, pea-sized brownish or yellowish, somewhat translucent discrete, glistening, smooth, flat tumors, found mostly on the trunk. They grow paler on pressure, and do not seem to the touch to be sharply circumscribed.

NEUROMA of the skin is characterized by various sized fibrous tubercles, containing new nerve elements, having their seat primarily in the corium, whose development is attended by violent paroxysmal pains.

MYOMA of the skin consists of tumors composed of smooth muscular fibres. They are of a pale, rose or dull-red color, rounded or oval, pea- and bean-sized, slightly raised, solitary or multiple, and are not to be confounded with lymphangioma nor with molluscum fibrosum.

DERMATALGIA is characterized by distinct localized neuralgic pain in the skin or with a morbidly sensitive condition of the integument. The symptoms are varying, and the pain may be general or local—usually the latter, slight or severe. The affection is often associated with rheumatism, and may be symptomatic of organic disease of the central nervous system. The treatment depends upon the variety, whether symptomatic or idiopathic. In the former, the general condition demands attention; and in the latter, local application of the galvanic current, blisters and aconite plaster may be tried.

PRURITUS is a functional cutaneous disorder, characterized by itching without structural change. The sensation is variously described as a feeling of irritation, formication or tingling. The disease is a common one, and may occur at any age. Occurring in elderly individuals, it constitutes so-called *pruritus senilis*. The itching, as a rule, is paroxysmal, and is worse at night. The disease may be universal or local, usually the latter, occurring frequently about the anus, scrotum and vulva, where it may be most distressing. The causes are varied; in children, pruritus ani may be caused by worms in the bowel; in females, it may occur in connection with gestation, irregular menstruation, hysteria, organic disorders of the uterus and ovaries. It may also be associated with diseases of the kidney, albuminuria, diabetes mellitus, hepatic diseases, jaundice, also with diseases of the nervous system and genito-urinary tract. Pathologically, it is a disease of purely functional character, usually the result of reflex nervous action.

The diagnosis offers no difficulty, as the surface of the skin presents none but secondary lesions, produced by scratching or irritants. It may be confounded with pediculosis, but in the latter disease the secondary lesions are more extensive. With prurigo it has nothing in common except itching; in the former disease there is a distinct primary papular eruption. In the erythematous and papular varieties of eczema the primary lesions are usually characteristic. The disease demands both constitutional and local measures according to the cause, which should always be determined. The bowels should be regulated; if constipation exist, saline laxatives are indicated; if there be any dyspepsia, the diet must be regulated, and all indigestible articles of food prohibited. Where there is general debility, tonics, as quinine and strychnine, and belladonna may be prescribed; and where the kidneys are at fault, or the disease is secondary to jaundice, the alkalies may be used with advantage. Sulphur and its preparations, especially the hyposulphite of sodium, are sometimes useful. External treatment is always demanded. Hot water applications and alkaline baths and the tarry alkaline lotions are of service. Lotions are valuable containing carbolic acid and thymol, simple or as follows:

℞.—Acidi carbolici, . . fʒss to fʒj.
Potassæ, ... fʒss.
Aquæ, ... fʒiv.—M.
Sig.—Use as a lotion, diluted with water.

One containing corrosive sublimate may also be given:

℞.—Hydrargyri bichloridi, . . . gr. viij
Alcoholis, ... fʒiv.
Aquæ, ... fʒiijss.—M.
Sig.—Use as a lotion, diluted.

Essence of peppermint and glycerine, equal parts; dilute hydrocyanic acid, one to four drachms to the pint of water; and hyposulphite of sodium, one drachm to the ounce, may prove useful. Of the numerous formulæ, the following may also be mentioned:

℞.—Boracis, ... ʒij.
Glycerinæ, ... fʒss.
Spts. camphoræ, ... fʒj.
Aquæ rosæ, ... fʒvjss.—M.
Sig.—Lotion.

℞.—Fol. belladonnæ,
Fol. hyoscyami, . . . āā ʒij.
Fol. aconiti, ... ʒss.
Acidi acetici, ... fʒj.—M.
Sig.—Lotion, to be diluted with water, one drachm to the ounce.

℞.—Camphoræ,
Chloralis hydratis, . . . āā ʒj.
Ungt. aquæ rosæ, ... ʒj.
M. ft. ungt.
Sig.—Apply several times daily.

Pruritus hiemalis is a name employed to designate an irritable condition of the skin accompanied by itching and occurring during the winter months. The affection may occur in different degrees of severity and is usually most severe at night. As the spring approaches, the disease gradually disappears, but generally reappears the next autumn. It may attack any part of the body, although it is found most frequently upon the lower extremities. Where it has existed for some time, excoriations may result from scratching. The treatment is palliative, and consists of vapor baths and the use of the various emollient ointments and lotions referred to.

ORIGINAL ARTICLES.

A CASE OF SARCOMA OF THE SKIN AND CELLULAR TISSUE ABOUT THE ANKLE, WITH REMARKS.[1]

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THE clinical interest of the following case furnishes me with a sufficient excuse for its publication.

Edward M., aged eighteen, native of Switzerland, a delicate-looking youth, came under my care at the Montreal General Hospital in April last, suffering from an ulcerated swelling about the left ankle. No history of struma or rheumatism in his family, and he himself has, with the exception of the present disease, always been healthy.

[1] Read before the Montreal Medico-Chirurgical Society, June 27, 1884.

He gave the following history of his case:

Some six years ago, while running, he fell and injured his left ankle-joint. The doctor told him it was dislocated, but after six weeks' rest the pain disappeared, and he could walk as well as ever; the swelling about the joint due to the injury, however, never entirely disappeared. A year subsequent to the above-described accident the ankle again became painful, and the swelling and tension markedly increased. His doctor, thinking an abscess had formed, opened the swelling, but failed to get pus, blood only escaping from the incision; this incision has never entirely healed, but ever since has remained open as a sinus, discharging a thin sanious pus. Three years ago he was kicked by a horse on the affected ankle; this caused an aggravation of the pain and swelling. The ankle-joint itself since the first accident has apparently never been affected, and its movements have always been free and comparatively painless, but the swelling on the inner side has been slowly increasing in size, and at different points sinuses, which discharge a thin pus, have formed.

When I first saw him, the parts about the inner side of the left ankle-joint were of a shiny, dusky-red color, and considerably swollen. The swelling extended from a point several inches above the tip of the internal malleolus to below the tarsal joint, it also extended laterally to the sole of the foot, half way across the instep, here the skin over the swelling was quite normal. There was also fulness over the tendo Achillis and the parts behind the internal malleolus. Near the edge of the swelling were several reddish tuberculous nodules the size of large peas. There were also a number of sinuses in the upper part of the swelling, and near the centre a spot of ulceration the size of a ten-cent piece. The swelling, which was not at all well defined, on pressure gave a sense of fluctuation, or rather felt like a mass of some semifluid substance. During pressure no pus exuded from any of the sinuses. There was but little pain in the part, and patient only complained when his foot was handled a little roughly. On probing the sinuses carefully no necrosed or carious bone could be felt.

Not feeling perfectly sure of the diagnosis, but supposing from the semi-elastic sensation conveyed by pressure, and also the history of the case and the evident healthiness of the ankle-joint itself, that the disease was some form of neoplasm, I decided to place the lad under ether and carefully explore the parts affected. This I did after observing the case for a day or two. I made a free incision in the long axis of the swelling over the inner malleolus, and after cutting through very thick infiltrated skin, came upon a lot of tissue looking like granulation-tissue; this substance appeared to be in pockets, and could be squeezed out by using some force. The lining membrane of these pockets was smooth and shiny. I cut through the whole thickness of the swelling and was still superficial to the annular ligament of the ankle and the tendons which pass under it; the movements of the tendons were in no way interfered with. Feeling sure I had to do with a new growth, I sent some of the substance taken from the pockets to my friend Dr. Wilkins, for microscopical examination, and he pronounced it a very good example of round-cell sarcoma.

On consultation with my colleagues, amputation of the leg was decided on. The lad and his friends, on learning the serious nature of the disease and the danger of delay, at once consented to the amputation.

I omitted to mention that the glands in the groin were much enlarged, one, below Poupart's ligament, had increased to the size of a pigeon's egg. I looked upon this condition of the glands as purely inflammatory, knowing the rarity with which sarcomatous tumors secondarily affect the glands, and also knowing that they had been enlarged ever since the first accident. In the interval between the making of the exploratory incision and the amputation, the swelling had slowly increased in size and extent, and the incision had rapidly filled up with coarse granulation-tissue.

I amputated the leg on May 17th at some distance above the disease, dressing the stump, as I usually do in amputations, with iodoform and pads of sublimated jute. In this case I made use of decalcified bone drains, which, owing to their collapse, had to be replaced on the second day by rubber tubes. From this time the case progressed favorably, the temperature after the third day never reaching 99°, and in less than three weeks' time, with three dressings, the wound was practically healed. The enlarged glands below Poupart's ligament gradually diminished in size; and when last seen a few days ago, the lad was in good condition, felt well and strong, and the enlarged glands had almost entirely disappeared. Whether or not he will have a return of the tumor in some other part remains for time to show. Owing to the long duration of the growth and its being of the most malignant variety of the sarcomata, it is possible that infection may have been conveyed to other parts.

This case is instructive chiefly on account of the difficulties it presented for diagnosis. In the first place, the situation was an unusual one for a sarcoma; again, it resembled more some chronic form of inflammation connected with periosteal or bone disease than a sarcomatous tumor and it was only after a careful exploratory incision and a microscopical examination that its true nature was made out. I need not dwell upon the importance to the patient of a correct diagnosis in these cases, for sarcoma, and especially the round-cell variety, unless removed, is a fatal malady. The patient before coming under my care had been treated for some months on the supposition that his affection was of an inflammatory nature. What led me to suspect a new growth was the existence of apparent fluctuation with the presence of numerous sinuses, the freedom from pain on movement of the joint and the absence of any carious or necrosed bone.

The long duration of the tumor, and the fact that it can be directly traced to traumatism as its cause, add further interest to the case. Cases have lately been reported by Mr. Barwell and others in which injury was followed by an acute and rapidly growing sarcoma; this is comparatively rare, but slowly grow-

ing sarcomata not infrequently follow injuries, a fact which was pointed out by Billroth many year ago.

It is of rare occurrence that the skin of the parts about the foot is affected with sarcoma; the more common forms of sarcoma of the lower extremity being connected with bone itself or the parts in connection with bone. When the skin is the seat of a sarcomatous tumor it is of the spindle-cell variety, as a rule, round-cell sarcoma being very rarely seen in connection with the skin.

Prof. Markoe, in THE MEDICAL NEWS of April 26, 1884, reported a series of cases of what he calls "Sarcoma of the Sheaths of Tendons about the Foot." His cases closely resemble that which I have just narrated to this Society. The skin, however, was not involved in Dr. Markoe's cases, the disease being confined to the parts immediately beneath. It seems to me that Dr. Markoe's description of his cases hardly bears out the idea put forth by him that the tumors were connected with the sheaths of the tendons.

One thing is certain, that these sarcomatous tumors about the foot are of rare occurrence, and if their true nature is not ascertained in time the life of the patient will be endangered, for though at first apparently innocent, sooner or later they develop the greatest malignity.

LAPAROTOMY, WITH REMOVAL OF A CYSTO-FIBROMA OF THE UTERUS AND A SMALL CYST OF BROAD LIGAMENT, TOGETHER WITH BOTH OVARIES AND FALLOPIAN TUBES.

BY MANNING SIMONS, M.D.,
OF CHARLESTON, SOUTH CAROLINA.

MISS X., aged 29, governess, American, consulted me in September, 1883, in relation to an abdominal tumor. She had always enjoyed good health and had been accustomed to an active life. She contracted malarial fever in the fall of 1882. She came to Charleston for treatment on account of the chills and fever into which her acute attack had degenerated. At that time she was pale and anæmic, but soon recovered her ordinary health after removal from the malarious region in which she had been living. I did not see her again until September, 1883, when she returned to Charleston to seek advice on account of the tumor.

She stated that in the summer of 1882 she received a severe blow on her abdomen by falling against a table. Beyond the pain and soreness for a few days, she attached no importance to this accident. In February, 1883, she observed a lump in the right side of the abdomen, which was hard but movable. She suffered intense pain in the abdomen, accompanied by nausea and a burning sensation. This pain was increased by stooping to lift anything, and she was very much fatigued by even a short walk.

About the last of April she noticed that the "lump" had shifted its position, appearing on the left side, accompanied by a good deal of soreness and pain. About this time her left leg began to swell and there was enlargement of the glands of the groin on the same side. This œdematous condition of the limb disappeared and returned from time to time.

In June the tumor assumed a position in the middle line of the abdomen and gave no pain or inconvenience except by pressure upon the bladder. There was no menorrhagia, but with the first appearance of the tumor the menstrual period was prolonged for two or three days beyond the usual time. She had, however, since that time been very regular both as to time and quantity of the flow.

In September, when she consulted me, I found a tumor which occupied the abdomen in the position and to about the extent of a pregnant uterus at seven months, reaching up to the umbilicus, completely filling the abdomen below that point and passing below the brim of the pelvis. The tumor had a perfectly solid feeling, and but for this might very readily have been mistaken for the pregnant uterus, which it closely resembled in shape. It was perfectly smooth. On vaginal examination the cervix was found to be that of a virgin, but the tumor could not be reached. By the bimanual method, the uterus was slightly moved by movement of the tumor. By rectal examination the uterus could be detected pressed downwards, backwards, and to the right side. For obvious reasons I did not explore the uterus with the sound.

After several examinations I became satisfied that there was a tumor, almost, if not completely solid, and probably connected with the uterus. From the nature of the case this connection could not be decided upon until the sound had been employed, and under the circumstances I determined to have a consultation before it was used. Prof. R. A. Kinloch having been called in, we passed the sound into the uterus, and it entered about three and a half inches, and to the right, taking the course indicated by the rectal examination as the position occupied by the uterus. On moving the tumor the handle of the sound could scarcely be said to deviate from its position to the right or left. We decided to leave the case, undetermined as to diagnosis because of some of its features, until another meeting, which should be held after the next menstrual period. During the next menstrual period I made an examination with the speculum, and saw the discharge issuing from the os, and in this way eliminated to some extent one of the elements of difficulty in the way of confirming a diagnosis. In February we made another examination, and on this occasion again passed the sound, with the same result as on the previous occasion.

In the meantime the tumor had increased much in size and its pressure-effects had become very painful and distressing to the patient, rendering it almost impossible for her to walk but a short distance, by reason of the weight and interference with respiration. She lost weight rapidly, and her face presented a distressed, pinched, and anxious expression. Our diagnosis was fibro-cystic tumor, connected closely with the uterus. It was determined to give her the benefit of an operation, which should be exploratory in its nature, but if there should be any reasonable prospect of removing the tumor with or without its

connections, with a chance of saving life, the operation was to be completed. My patient was removed to the St. Francis Xavier Infirmary, a new hospital recently erected in the western portion of the city, in full view of the Ashley River, and to a great degree isolated from other buildings. She was admitted on April 1st, one week before the day fixed upon for the operation, and carefully prepared for the ordeal by daily warm baths and frictions of the skin, regulation of the bowels, and a selected diet.

The operation was performed on April 8th, twenty days after the preceding menstrual period, with the assistance of Drs. R. A. Kinloch, Wm. H. Huger, W. C. Ravenel, P. Gourdin DeSaussure, and John L. Dawson, Jr. There were no spectators, and but five assistants, who carefully disinfected their hands.

Twenty minutes before the administration of the anæsthetic a hypodermatic injection of atropiæ sulph. gr. $\frac{1}{150}$, and morphiæ sulph. gr. $\frac{1}{4}$, was administered. The anæsthesia was first accomplished with chloroform and continued with ether.

Operation. An incision was made in the median line between the umbilicus and pubis, four inches in length, and the parts successively divided until the transversalis fascia was cut through; there was then exposed to view the subperitoneal tissue loaded with fat, which was removed piecemeal with scissors.

At this stage attention was devoted to the arresting of hemorrhage, which was very free. The peritoneum was then opened, no ascitic fluid escaped, and the tumor brought into view. It was of a white, pearly color, and solid to the touch except at one point, which gave an indistinct but delusive sensation of fluctuation. The sound was swept around and no parietal adhesions discovered. The patient was turned upon her right side and a trocar of small size was introduced into the tumor, giving in its passage the feeling of perfect solidity and density. Nothing save a little blood escaped from the canula. Coursing over the surface of the tumor were large vessels with very friable walls, which became ruptured in handling the tumor, and from these there was an active hemorrhage which could not be restrained either by forceps or ligature. The abdominal incision was rapidly extended with scissors, downwards to the pubis and upwards to the left of the umbilicus, to about two inches above the latter. The tumor was then lifted with difficulty out of the abdomen, the edges of the abdominal wound being as soon as possible covered with soft cloths wrung out in a warm solution of carbolic acid to prevent the passage of blood into the cavity, as well as to obviate the loss of temperature. It was found that the tumor was connected with the uterus at its upper border and to the left side by a pedicle about one and a half inches in length and two and a half inches in thickness. There were two considerable adhesions of the omentum to the tumor, and another adhesion apparently of the ascending colon. These adherent structures were tied, peeled off from the tumor, and dropped into the abdominal cavity. The pedicle was transfixed near the uterus by a long steel pin, and below it was placed a solid rubber cord which was tied in tension, effectually constricting the parts. The tumor was then ablated, no hemorrhage occurring from the stump. The pedicle was again transfixed below the rubber cord, with a needle armed with a double silk ligature, and tied in two portions. The ligature was next passed around the whole stump, including both halves, before it was finally secured.

The elastic cord was now removed and a wedge-shaped piece taken from the centre of the stump, leaving two lateral flaps. The effort was at the same time made to preserve as much of the peritoneal covering as possible, by which to invest the flaps. These flaps were then brought together with an uninterrupted suture of fine silk. This being accomplished, it was discovered that there was some subperitoneal hemorrhage coming from the track of the ligature surrounding the pedicle. It therefore became necessary to inclose the stump with another ligature between the uterus and the first ligature. This was a difficult matter, as there was now no space left on the pedicle, and this ligature had to be put upon the uterus itself.

To accomplish this a single silk thread was used, and to keep it in place (for the tendency was for it to slip into the track of the main ligature), as it encroached considerably upon the uterus, at the suggestion of Dr. Kinloch, I took a series of superficial stitches in the uterine tissue about three-fourths of an inch apart, until the stump was completely surrounded like the mouth of a purse. When this ligature was drawn close the hemorrhage ceased. This fine ligature was cut short, as was the main one, and the uterus dropped into the cavity.

The ovaries were then examined; both were found with beginning cystic disease, and in size equal to a large fowl's egg. These, together with the Fallopian tubes, were removed, their connections having been tied with fine silk ligatures. In connection with the broad ligament of the right side was found a small cyst which was likewise included in a ligature and removed.

The abdominal cavity was carefully sponged, and this process was continued until the sponges were returned unstained. The abdominal wound was closed with nine silver sutures passed one inch from the edge of the incision, the peritoneum being carefully included to the same extent. Before these sutures were passed, a flat soft sponge was interposed between the abdominal wound and the intestines, to intercept any blood which should escape from the punctures. At the lower angle of the wound a Thomas double-current rubber drainage-tube was introduced to the bottom of Douglas's cul-de-sac. Through the rubber tubing attached to the arms of the drainage-tube, with a Davidson's syringe the abdominal cavity was freely washed out with a warm one to forty solution of carbolic acid until the returning fluid was clear. A portion of this fluid was allowed to remain in the cavity. Seven superficial sutures of silk were introduced in the spaces between the deep sutures. At this stage an annoying hemorrhage occurred from a superficial vessel in the abdominal incision which gave some trouble. This being controlled, the incision was dusted with iodoform, and especially around the tube at the inferior angle; over this was placed borated cotton, and the whole dressing kept in place with a flannel bandage. The operation ex-

tended over an hour, but much of this time was consumed in arresting hemorrhage before the abdominal cavity was opened.

The tumor weighed seven pounds and measured in its greatest circumference 25½ inches; in its transverse circumference 20½ inches, and in its vertical circumference 22½ inches. It was of dense fibrous structure, giving the sensation of cartilage under the knife. It contained two small cysts; one of the size of a fowl's egg near the centre, the other at the periphery was the size of a goose's egg.

The patient reacted promptly after the operation; the temperature being 99° at 3 P. M., one hour and a half after she was put to bed. Nausea and vomiting were urgent for forty-eight hours. During the first twenty-four hours absolutely no nourishment was given, and nothing save occasionally a small piece of ice to allay thirst. On the evening of the second day milk and lime-water were administered every hour in teaspoonful doses. Menstruation appeared on the second day. On the fourth day there was hemorrhage from the superficial wound. The dressings were changed and the wound dusted with iodoform. The drainage-tube was also removed, as up to this time there had been no discharge through it. A tent was placed in the track occupied by the tube.

On the sixth day the patient took beef-tea with relish; up to this time she had only been allowed milk and lime-water. The wound was healed except at the lower angle. Removed the tent, which had some bloody matter upon it, but there was no unpleasant odor. No discharge followed the tent. On the seventh day as there was some tendency to sweating, the abdominal cavity was washed out with a solution of common salt carbolized; ʒj of salt, ʒijss of carbolic acid to the quart of water. With the first flow of the solution some blood-tinged matter returned immediately from the track of the drainage-tube.

It was evident that this track was separated from the general cavity of the peritoneum by plastic deposit. On the eighth day the nine silver sutures were removed and adhesive strips were applied to secure the line of incision from strain. The original track of the drainage-tube was washed out each day from this time until the fifteenth day, when it was omitted because the part had become almost entirely filled up with granulations; the discharge amounted to very little and was pure and clear. On the evening of the eighth day ordered calomel gr. jss and white sugar gr. xx at bedtime. On the ninth day administered ʒij castor oil, which operated four times freely. On the twentieth day the superficial sutures were removed.

The highest point reached by the temperature during the progress of the case was 100.75° and this only on one occasion on the second day at 6.40 P. M., but fell again at 10.20 P. M. to 99.25°.

It was necessary only to pass the catheter twice, viz., on the first and ninth days after operation.

There was never at any time evidence of peritonitis, and the only suspicion of septic infection was in the relaxed and sweaty condition of the skin observed for the first time on the seventh day. It was this symptom which was taken as an indication for washing out the track of the drainage-tube.

The patient was in a condition to get up at the end of the third week, but as I was to be absent from the city for a week she was detained in bed until the end of the fourth week, for fear that there might be some imprudence unless she was carefully watched.

Remarks. I am induced to report this case because of the interest which is at the present time manifested in operations for the removal of tumors connected with the uterus; whether these operations have for their object the ablation of the tumor alone, or this together with the uterus itself, or the uterine appendages, with the hope of bringing about a reduction in the size of the tumor.

The case is interesting for the reason that during the course of the after-treatment the patient never at any time presented symptoms of an alarming nature, either from shock, hemorrhage, peritonitis, or septic infection. It is also a success scored for the intraperitoneal method of treating the stump, although the uterus itself was involved in the ligature. One of the most frequent causes of failure in operations of this nature is hemorrhage from the stump after it has been dropped into the abdominal cavity. This hemorrhage often exists to a small extent from the wound made by the needle in passing the ligature through the stump unobserved before it is dropped and becomes free in the abdominal cavity, partly from the more active circulation after reaction, and partly from the shrinking of the stump itself.

In this connection I would call attention to the method of applying the ligature to the stump employed in this case. After ligating the stump in halves, the ligature was made to encircle the whole stump before it was secured. Even with this precaution hemorrhage continued from the track of the needle employed in passing the ligature. The important point in restraining this hemorrhage was the manner in which the final ligature was applied. The difficulty encountered was to retain this ligature in place and overcome its tendency to slip from the uterus. This could not have been accomplished except by the taking of superficial stitches in the tissue of the uterus.

The final success of the case was due to absolute cleanliness and drainage.

THE ANTRUM OF HIGHMORE, AND SOME OF ITS DISEASES.

BY D. H. GOODWILLIE, M.D.,
OF NEW YORK.

THE antrum is a large cavity in the body of the maxillary bone. Above is the floor of the orbit, internally the nasal wall, below the alveolar process. It varies in size and capacity (one to eight ounces), and is larger in the male than the female; it diminishes in old age and after the loss of the teeth. The two antra may be unsymmetrical in size and shape, and sometimes extend into the malar bone, forming a second cavity. It is lined by mucous membrane, and communicates with the nasal cavity in the middle meatus by an opening that varies in size.

If the sinus is large, the second bicuspid and first and second molars may be in close relation to the floor. The roots of the first molar often pierce through the bony floor, and are only covered by the mucous lining of the antrum. The posterior and middle dental nerve courses in the posterior and anterior walls. Disease seldom originates in this sinus, but it is often invaded by disease from without.

Suppuration in the antrum, in the great majority of cases, is the result of suppurative pulpitis, most commonly from the first molar. Caries of the tooth sets up suppurative pulpitis, and the discharge passes through the apices of the roots into the antrum. If the trouble is from the other adjacent teeth, the pulpitis will result in a maxillary abscess, which may then extend into the antrum.

In struma, syphilis, and mercurial poisoning the inferior and middle turbinated bones become necrosed with the antral wall. Trouble in this sinus is sometimes the result of traumatic causes.

Septicæmia is one of the dangers in pent-up pus in the antrum—indeed, is more or less present in nearly all cases, particularly so if there is also a maxillary abscess.

Symptoms of antral abscess are at first a dull aching pain, and as the disease advances infra- and supra-orbital neuralgia, throbbing pain, with redness, swelling, and fluctuation, with rigors and fever. As the pus accumulates, the nasal wall—the weaker one, is quite apt to be forced toward the septum, often producing complete stenosis of the nostril, with, possibly, a discharge of pus. If there is much continued pressure, the stronger wall shows signs of distention, with swelling of the cheek, or the palate is forced downwards. Occasionally the orbital wall will be forced upwards, producing exophthalmus.

Treatment consists in the evacuation of the pus by the extraction of the decayed teeth, and through the socket of the first molar as the most direct course to the floor of the antrum by means of a trephine. This is most efficiently done by the surgical engine. The opening should be one-fourth of an inch in diameter to give free vent to the discharge. This should not be allowed to close until all discharge ceases.

If the case is of long standing,an opening should also be made from the inferior meatus through the nasal wall into the antrum. The sinus is to be kept clean by thymolized water. or bichloride of mercury (1 in 1000) and water. Boric acid or iodoform and camphor powder is to be blown in by means of an insufflator.

If the antrum trouble is the result of constitutional disease, appropriate remedies are to be used in connection with the local treatment.

Catarrh of the antrum is a disease in its earlier stage too little recognized. It coexists with catarrh of the nasal cavity, and is often the primary cause. The opening from the nasal cavity becomes enlarged, and the fetid catarrhal secretion passes into the nasal cavity. This is one source of the trouble called ozæna. There may also be necrosis of the inferior turbinated bone.

The treatment in such cases is to make a free opening from the inferior meatus into the antrum, all necrosis to be removed if any exists. It is to be kept thoroughly cleansed and the powders blown in.

Hydrops antri is a disease characterized by a gradual painless distention of the walls of the antrum, probably by the changes constantly going on in the pent-up secretion. This fluid is clear or yellowish, frequently containing flakes of cholesterine, and is supposed to be the contents of cystic growths within the antrum.

Treatment consists in trephining, cleansing, and use of the powders.

The antrum is often invaded by nasal tumors, which occasionally pass through the antrum and emerge externally into the cheek.

Malignant disease occasionally has its seat here.

Foreign bodies, such as teeth, are found in the antrum and sometimes are in malposition, or by some accident are forced into the sinus.

Lacerations and fractures of the alveolus, by extracting the molars, are frequent causes of antrum trouble.

CASE I. *Suppurative disease of the antrum of Highmore, with dislocation of the cartilaginous nasal septum of twelve years' standing.*—Dr. D. M., of Ontario, Canada, consulted me in November, 1879, and gave the following history: In 1865, had pain in his second left superior molar tooth, and an unsuccessful attempt was made to have it extracted. This probably resulted in rupturing the vessels of the dental pulp, as the doctor says the tooth was started from its socket and then pushed back again. Some time after, from intense pain and swelling of the face, a second attempt was made to extract the tooth. This was not entirely successful, as a root was left in the jaw. From this time the discharge began, and continued until I saw him, more than twelve years after.

He presented the following condition: first and second molars gone from the left superior jaw. Above the alveolus at the position of the second molar, was a fistulous opening, made by a trephine some years ago into the antrum. In this opening he wore a hard-rubber drain-tube, but as it was small in calibre and too high up in order to drain the discharge from the antrum, it was of very little use. It also excited granulations in the cavity. A gelatinous polypus was found in the left nostril, growing from the middle turbinated bone.

This hung by a pedicle over an opening made by necrosis of the inferior turbinated bone and the nasal walls of the antrum.

From the blowing of the left nostril by closing the right with the thumb, to free it from the constant discharge, the lower end of the cartilaginous nasal septum was dislocated and turned into the left nostril, preventing respiration, except when forced. In the pharynx, a muco-purulent track was to be seen on the left of the vertebral ridge, caused by the discharge passing down from the posterior nares. This produced a good deal of expectoration. This trouble continuing for so long a time had very much affected his general health, and prevented him from attending to all his professional duties. On the doctor's first visit in November, 1879, I only removed

the polypus, as it was necessary for him to return immediately home to meet some professional engagements.

In April, 1880, he returned and under an anæsthetic I made first an operation on the dislocated nasal septum. An incision being made through the soft parts, I amputated the protruding cartilage of the septum. The soft parts were brought together and held by small silk sutures; this healed by first intention, and in a weeks' time it would be difficult to tell where the incision had been made. The next part of the operation was the trephining through the alveolar process at the position of the first molar, directly into the bottom of the antrum, by means of a large bone-cutting drill driven by the surgical engine. This opening gave exit to a fetid discharge pent up in the cavity of the antrum. The last part of this operation was the removal, by means of the revolving bone-cutters, of the necrosed turbinated bone and the naso-antral wall, through the anterior nares. This made an opening from the nose into the antrum, extending from the floor of the inferior meatus to the middle turbinated bone and antero-posteriorly about an inch. There was considerable hemorrhage, which was easily controlled.

Through these openings the antrum was freely washed out with thymolized water, and medication applied, which consisted in blowing into the antrum the iodoform and camphor powder by means of the insufflator. There were present at this operation Drs. Farnham, Carey, Warden, and Bucklin of New York; Marvin, of Brooklyn; and Braden, of Michigan. Twelve months after the operation the mucopurulent discharge ceased, and he is now in robust health. The respiration through the occluded nostril is quite free. The opening from the mouth into the antrum has now closed up. A permanent opening will remain in the naso-antral wall where the necrosis was removed.

CASE II. *Suppurative disease with exophthalmus.*—In July, 1881, Dr. Carey referred to me Mrs. A. C., who had extensive swelling of the left cheek, with exophthalmus. Nostril on that side closed. She suffered great pain; teeth on that side much decayed. Treatment consisted in removing the decayed teeth and trephining through the alveolus into the antrum. The antrum was also trephined through the naso-antral wall in the line of the inferior meatus. The pent-up fetid pus flowed freely from the antrum through these openings and gave her great relief from pain. The sinus was kept thoroughly cleansed and the swelling and exophthalmus gradually passed away.

CASE III. *Tooth found in the antrum.*—I was consulted in 1869 by Mrs. S. A., of Philadelphia, Pa., who gave the following history: Having pain on the right side of her mouth, she had some decayad teeth extracted. Severe pain soon returned and had continued some months before I saw her. There was great swelling of the jaw and face; palate forced downwards; distention of the naso-antral wall, with some discharge from the nostril and alveolar process. Administered an anæsthetic and trephined through the track of the fistulous opening in the alveolar process, which was necrosed into the antrum. On entering the antrum, the trephine struck against some hard foreign body. After the opening had been enlarged, a tooth was found in the antrum and removed with all the necrosed bone. This operation removed the entire floor of the antrum. As all the periosteum was preserved, the case recovered rapidly and left very little deformity.

The probable explanation of the presence of this tooth in the antrum is as follows, viz.: A suppurative pulpitis was followed by a maxillary abscess around the roots of the molar tooth; the pus finding its way into the antrum produced inflammation and suppuration, resulting in alveolar necrosis, and when the teeth were extracted this one was forced into the antrum in attempting to apply the forceps.

CASE IV. *A tooth developed in the antrum.*—Isaac C., aged 18 years, was brought to me by Dr. Carr. The young man had been suffering pain in his right superior maxilla which commenced six years before and had steadily increased up to the time I saw him. It was thought at first to be an alveolar abscess and the doctor lanced it, but with only temporary relief to his pain. There was found on examination the following condition: There was a swelling commencing at the canine fossa and extending back to the hamular process. Stenosis of the right nostril with nasopharyngeal catarrh. All the teeth on that side of the mouth were developed and in normal position with the exception of the canine. From the absence of the tooth and the nature of the discharge that occasionally came away, together with the other symptoms, I was of the opinion that it was a dentigerous cyst.

Treatment consisted in placing the patient under an anæsthetic, and pulling well back the cheek by means of a retractor, and in making an incision from the canine fossa backwards one and one-half inches, and three-quarters of an inch above the border of the gum. The periosteum was now denuded from the bone, and by means of the revolving bone knives the cyst was opened into, and quite a quantity of an amber-colored liquid escaped. On a careful examination of the interior of the cyst, the canine tooth was found fully developed and lying in the bone of the floor of the antrum, the root presenting anteriorly. The soft parts that were denuded were united by suture, the anterior corner being left for the purpose of cleansing the antrum and cyst. A reproduction of bone took place from denuded periosteum, and six months after nothing remained to show that any operation had been performed. The stenosis of the nostril was relieved by extirpating the inferior turbinated bone by means of the revolving scissors and surgical engine, in order to make a free passage.

CASE V. *Abscess of the antrum of ten years' standing.*—W. N., aged 51 years, born in England, had tooth disease commencing ten years before, from which time he has had neuralgia with nasal catarrh. After treatment by his family physician he was referred to a specialist, by whom he was treated for nasopharyngeal catarrh, but he steadily grew worse and gave up treatment. Suffering from pain and the discharge, he was unable to sleep at night in bed, but reclined in a chair.

When I first saw him he was suffering intense

infra- and supra-orbital neuralgia, with rigors and fever. Slight redness and swelling of the right cheek. Muco-purulent discharge from the right nostril. All the molars and the second bicuspid were gone. The bicuspid had been removed not many days before.

Treatment consisted in trephining through the alveolus into the antrum and in enlarging the opening in the naso-antral wall into the inferior meatus. The discharge was very fetid. The antrum was kept thoroughly washed out and boracic acid blown into the antrum and into the nostril. The passages were kept open and the treatment carried on for several months, and he entirely recovered.

MEDICAL PROGRESS.

SUBCUTANEOUS INJECTIONS FOR CHOLERA.—SAMUEL holds that cholera is a process which causes death by an incoercible transudation. The local treatment (anti-parasitic or antidiarrhœal) cannot, on account of the rapid removal of the remedies or their extreme dissolution, give any good result. General treatment in this way is also doubtful. It is only necessary to maintain the circulation for twenty-four or thirty-six hours, and he recommends multiple injections under the skin, in different regions of the body, of solutions of six parts (by weight) of common salt and one of bicarbonate of soda to one thousand of distilled water. These injections should be kept up during the whole period of asphyxia.

At the meeting of the Verein für innere Medicin of Berlin, on July 14, DR. KRONECKER said that he considered the intraorganic injection of common salt as the really effective method of combating cholera. The quantity to be used is not a matter of indifference, and experiments on animals do not give the needed data; one animal will support well a quantity which would be fatal to another. For man, from the results of hypodermatic and nasal injections, it seems that a solution of seventy-three parts of salt to one hundred of water (by weight) is the quantity best supported.

Should the injections be intra-arterial, intravenous, or simply subcutaneous? Kronecker has always injected the solution into the veins; this is the surest method. But care should be taken that no more than 20 c.cm. (ʒv) enter the circulation per second; for this purpose a graduated flask should be used.

The Society appointed a commission of seven members to investigate the subject.—*Berliner klin. Wochenschr.*, July 28, 1884, and *Wiener med. Presse*, July 27, 1884.

THE CONSEQUENCES OF EXTIRPATION OF THE THYROID GLAND.—J. WAGNER has just completed a series of experiments, on this subject, made on dogs and cats. After extirpating the thyroid gland, he studied the nervous disturbances which followed. The most of the cats operated upon were only a few weeks old. After complete extirpation, trembling of the extremities and fibrillary muscular spasms occurred, which, though scarcely perceptible at the beginning, became more pronounced later, and interfered with the locomotion of the animal. Sometimes the muscular tremors amounted to clonic cramps, and they, in turn, were succeeded by tetanic convulsions. The locomotion was stiff and sprawling. The respiration was dyspnœic during the cramps. The sensibility was very much diminished, and perhaps there was also some paræsthesia. In one case, there was clearly a marked increase in the mechanical and electrical nervous irritability. In every case, death occurred between the second and fourth day, and there was a tendency in the animals to run backwards. Nothing noteworthy was found at the post-mortem examinations.—*Centralbl. f. d. med. Wissensch.*, July 26, 1884.

THE MICROBE OF SYPHILIS.—At the meeting of the Société de Biologie, on July 12th, MM. MARCUS and TORNÉRY communicated the results of their researches on the microbe of syphilis. They conclude that:

1. An easily colored coccus, occurring in colonies, is found in syphilitic products, and in cultures from them.

2. These cocci are easily cultivated in an infusion of peptonized beef, to which gelatine and an alkali have been added.

3. They are found in indurated chancres, and in the lymphatic ganglia.—*Gaz. Hebdom.*, July 25, 1884.

EXTIRPATION OF THE CARCINOMATOUS UTERUS.—A. N. SOLOWJEFF reports ten cases in which he removed the carcinomatous uterus, by the vaginal method, in 1881–83. The results were as follows: Seven recovered, and are living now, and three are dead. Of the recoveries two (one twenty and one eighteen months after the operation) have no return of the carcinoma; in one case recovery seems to be complete; in two no anomalous conditions are found near the cicatrix; in one there are nodules in the cicatrix; one lost sight of. Of the three fatal cases the disease returned in the broad ligaments in one; a portion of the growth was left in the broad ligament in another; and the third died of sepiticæmia.—*Centralbl. für Chirurgie*, August 2, 1884.

THE INFECTIOUSNESS OF THE AIR IN ROOMS OCCUPIED BY PHTHISICAL PERSONS.—L. VON WEHDE has recently made experiments on this subject by collecting the dust from the air in rooms occupied by phthisical persons. After one, one and a half, and two days the glycerine appeared clouded, to the naked eye. Water, into which dust, collected on a dry plate, was placed, also became clouded. Fifteen animals were then inoculated with the soiled fluids. The inoculations succeeded in eleven cases; the other four "died soon after the inoculation of other causes (?)"—*Centralbl. f. d. med. Wissensch.*, August 2, 1884.

TERATOMA OF THE PITUITARY GLAND.—H. BECK reports, in the *Prager Ztschr. für Heilkunde*, 1883, Bd. iv. Hft. 5 *u.* 6, his examination of a tumor of the pituitary gland, which Chiari found in a woman seventy-four years of age. It had caused trouble of vision, by producing a flattening of the optic chiasm. The tumor was the size of a walnut, and contained cysts with gelatinous contents, teeth, and bones; the cavity was lined with ciliated epithelium.—*Centralbl. f. d. med Wissensch.*, August 2, 1884.

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INTRAVENOUS INJECTIONS.

IT must be reluctantly admitted that the operation of transfusion of blood, philosophical as it seems, and powerfully as it appeals to the earnest desire of every true physician, that he may do some great thing toward saving a valued human life as occasion requires, has not fulfilled its early promise, and has consequently fallen out of favor with surgeons here as elsewhere. Among the causes of this decadence in popularity, may be mentioned the great danger that, even in so-called defibrinated blood, minute masses of fibrin, or aggregations of red corpuscles, may act as emboli, and quickly cause grave or fatal disorders in the brain, lungs, and liver. Other objections are found in the difficulty of procuring healthy blood in sufficient quantity, at the moment when it is most needed, and to a less degree the chances of conveying disease into the body of the recipient. Within the past few months, however, so many reports of success abroad, by the intravenous injection of a solution of common salt and carbonate of sodium, representing the salines of the blood-plasma, have reached us, that it seems almost a duty for us to undertake new experiments in this country, in order to test the practical value of so plausible a method for obviating the tendency to death in cases of profuse hemorrhage.

In a remarkable instance reported among others by PROF. MIKULICZ, of Cracow, a young man, who had lost so much blood from a wound in the brachial artery that his pulse was barely perceptible and was beating at the rate of about one hundred and thirty per minute, was operated on by the gradual injection of twenty ounces (600 c. c.) of the compound salt solution, with immediate and obvious benefit and ultimate cure. Dr. Fux, of Laibach, records the case of another youth, who, in consequence of repeated hemorrhages from a neglected wound in the hand, had become profoundly anæmic, but was satisfactorily prepared for successful operation upon the injured member by an intravenous injection of eight and a half ounces (250 c. c.) of salt solution. Dr. Fux, as a result of his experience, fully endorses the assertion of Szuman that the injection of salt solution in acute general anæmia is an enormous advance in therapeutics, and deserves to be held in very high esteem as a surgical resource in threatened death from hemorrhage.

The solution employed by Mikulicz was composed of one part of carbonate of sodium, six parts of common salt, and one thousand parts of distilled or twice-boiled water, warmed in a bottle of the temperature of 104° F. (40° Cent.), and injected into the median basilic vein, by the mere weight of a column of the fluid twenty inches in height, contained in a funnel and rubber tube attached to the canula, which had been inserted into the vein. Great care was taken to insure complete antisepsis by transmitting a five per cent. carbolic acid solution, to wash out the apparatus previously, and the amount of salt solution slowly injected varied from seventeen to fifty ounces (500 to 1500 c. c.).

It seems to be proved by experiments upon animals, and also by clinical facts already in our possession, that the mortality in most cases of excessive loss of blood does not occur from scarcity of red corpuscles chiefly, but in consequence of the total bulk of the vital fluid being so far diminished that the vascular system, and especially the cerebral and coronary arteries, are not kept full enough to enable the organs concerned duly to perform their functions. That it is not the mere diminution of the solid constituents of the blood which is the essentially fatal condition, is shown by the facts that in profound anæmia the number of red corpuscles may fall to 500,000 per cubic millimetre, or one-tenth their normal amount, whilst the albumen and fibrin may also be very much reduced, in hypalbuminosis and hypinosis without destroying life.

Hence, if the favorable results already reported are confirmed by other observations under varying conditions, we believe that the operation of "Koch-salzinfusion" will speedily assume an important place, as a remedial measure against death from excessive loss of blood. Perhaps, indeed, it may ultimately take rank among the four or five surgical procedures, such as that of tracheotomy, and the operation for relieving strangulated hernia, which every physician should keep himself both *mentally* and *instrumentally prepared*, to perform at a moment's notice. It is ap-

plicable not only in cases of external wounds, but also in internal hemorrhage from gastric or intestinal ulceration, and in the uterine hemorrhage of abortion, or of placenta prævia, or from inertia after parturition is accomplished.

VAGINAL EXTIRPATION OF THE UTERUS.

THE subject of kolpohysterectomy, or removal of the uterus by the vagina, is very fully discussed by DEMONS, of Bordeaux, in the *Révue de Chirurgie* of August. He holds that while cancer of the uterus offers by far the most frequent indication for the operation, yet it may be given by myomata situated at the fundus of the uterus; when a myoma is of medium size and submucous, situated as mentioned, the patient may die from hemorrhage, and therefore, other means failing to stop the blood-flow, it is better to remove the uterus by the vaginal method. An indication for partial removal of the uterus is given by an irreducible inversion of the organ.

In determining the propriety of the operation in a case of cancer of the uterus, a most careful examination must be made, and for this it is necessary in many cases thoroughly to anæsthetize the patient,—at least the abdominal muscles must be completely relaxed. The examination is made by abdominal palpation, by vaginal and rectal touch. In a case suitable for the operation there should be no enlargement of the lumbar glands, no tumefaction of the broad ligaments, the vaginal cul-de-sacs should be free from swelling, of normal elasticity, and the uterus should be quite movable. This mobility is best tested by catching the cervix with a tenaculum, and drawing the organ toward the vulva, at the same time, as advised by Schröder, that rectal and vaginal touch are made, so that the broad ligaments can thus be included between the fingers, and their freedom from disease be ascertained.

The operation is to be rejected in case the disease involves simply the intravaginal cervix, for then removal of this only is advisable Even if the disease has extended to the internal os, supravaginal amputation of the cervix may be done, but total extirpation is necessary if the mucous membrane of the body is involved as well as that of the neck.

In the operation the patient is completely anæsthetized, and by means of continuous traction with Museux's forceps fastened to the cervix, the latter is drawn to the vulval orifice; then a circular incision is made around the cervix, when the finger is used to detach the uterus, keeping it close to this organ; the detachment is made but slightly behind and at the sides, but carried in front to the anterior peritoneal cul-de-sac; occasionally a probe-pointed bistoury may be necessary to divide very resisting portions of connective tissue. The peritoneum is opened, if possible, with the finger, if too resisting with the bistoury, and then two fingers are passed over the fundus of the uterus so as to draw it into the vagina; in some cases this eversion of the uterus cannot be effected by the fingers, and then a strong hook must be used for the purpose.

The next, and the most difficult step of the operation, is ligating the broad ligaments. For this a curved needle—Cooper's is advised—is required, and Demons uses catgut ligatures, No. 1 for the upper, and No. 2 or 3 for the two lower. After introducing the three ligatures on one side, and tying them, the ligament is divided either with a probe-pointed bistoury, or blunt-pointed scissors; next the ligatures are applied to the broad ligament of the other side, and it is then similarly divided; finally, the bistoury is used to cut the peritoneum posteriorly, and the uterus falls out. Demons states that it is unnecessary to remove the ovaries, as the patients do not have any acute pain at menstrual periods, and there is no intra-abdominal hemorrhage.

The statistics of the operation given by Sänger, in 1883, are quoted, showing that in 143 extirpations of the uterus—133 for cancer, 6 for prolapse, and 4 for myomata—72 per cent. recovered, while 28 per cent. died. While immediate recovery is then the rule even in cases of kolpohysterectomy for cancer, yet in the majority the disease returns in four or five months, and the patient dies in a year or fourteen months after the operation. Demons, while recognizing the difficulties of the operation, states that he has less fear in the removal of a mobile uterus, than in that of a nasopharyngeal polypus with multiple prolongations, or of a suffocating goitre.

LITHOLAPAXY.

WE cannot at this moment recall a single surgical operation which has so rapidly become an accepted procedure as lithotrity at one sitting. From the very date that PROFESSOR BIGELOW published in *The American Journal of the Medical Sciences*, six years ago, an account of his new method of dealing with urinary calculi, surgeons of all parts of the world have demonstrated the merit of his great achievement, and it is interesting to note that, in the hands of those having the greatest experience in the treatment of calculous subjects, litholapaxy has as effectually displaced ordinary crushing as the latter procedure has displaced lithotomy.

That the latter statement is strictly true is shown by a comparison of the three procedures in adults, as practised by the same surgeon. From two lectures delivered at the Royal College of Surgeons, and published in the *British Medical Journal* for July 12 and 19 of this year, we find that SIR HENRY THOMPSON has had 782 cases of operation for stone in adult

males. Among his first 200 cases, 48, or 1 in nearly every 4, were subjected to lithotomy. In his next 371 cases, 19, or 1 in every 19½, were cut; while in his last 211 operations, 15, or 1 in every 14, were lithotomies. VON DITTEL, as reported in the *Wiener med. Wochenschrift*, Nos. 3 to 11, 1884, lithotomized 46 of his first 100 patients, 32 of his second 100, and only 13 of his third 108, the ratio of those cut having been reduced from 1 in 2.17 to 1 in 7.69. In the crushing operations litholapaxy rapidly displaced ordinary lithotrity, and lithotomy was reserved, as a rule, for encysted calculi and stones of unusually large size.

That Bigelow's operation is safer than other operations for urinary calculi in adult males is proved by some other facts set forth in the lectures of Sir Henry Thompson. Thus, of 110 lithotomies, 39 were fatal, the mortality being 35.5 per cent., which is simply enormous. Of 478 ordinary lithotrities, 33 died, the mortality being 6.9 per cent.; while of 194 litholapaxies, 10, or 5.15 per cent., were fatal. These results clearly show that litholapaxy must supersede not only the old operation of crushing, but also cutting operations except in cases in which the stone is of exceptional size or hardness.

The results of rapid lithotrity, as performed by different operators, indicate a mortality of about 5.4 per cent. This death-rate does not appear to have been materially lessened by the experience of those who have had the most frequent opportunities to do the operation. Thus, Freyer's 76 cases show 3 deaths, or a mortality of 4 per cent. Von Dittel's 80 cases afford 5 deaths, or a mortality of 6.25 per cent., and Sir Henry Thompson's 194 operations have yielded 10 deaths, or a mortality of 5.15 per cent. The entire number, or 350 cases, show 18 deaths, or a mortality of 5.1 per cent., a result which may be improved upon, but with which we should have every reason to be satisfied.

THE ANATOMY OF THE LABIA MINORA.

IT has hitherto been generally taught in all works upon anatomy and obstetrics that the nymphæ are "folds of mucous membrane." But the recent researches of DR. HENRI CARRARD (*Zeitschrift für Geburtshülfe und Gynäcologie*, Band x. Heft 1) must lead to a rejection of this view. He states that, from his microscopic examination of normal nymphæ, their covering has histologically, in spite of its moist mucous-membrane-like appearance, the character of skin. Its superficial layers are formed of numerous non-nucleated, flat cells; it contains many well-developed papillæ and an abundant supply of sebaceous, but no mucous glands. Further, Carrard has found in the papillæ, as a constant condition of the terminal nerves, Meissner's corpuscles—an occurrence which is a strong argument against the nymphæ being formed of folds of mucous membrane.

Hildebrandt, in the handbook of Pitha and Billroth, has attributed vulval pruritus in many cases to enlarged capillaries in the nymphæ, comparing it to the itching caused by hemorrhoids. The pruritus observed in some cases of pregnancy, or of uterine fibroids, or of ovarian tumors—all conditions, in short, which induce a greater flow of blood to the parts, or hinder its return—may be thus caused. But Carrard has not observed this alleged enlargement of the capillaries of the nymphæ in pruritus, and, therefore, rejects Hildebrandt's explanation; but he did find upon microscopic examination of hypertrophied nymphæ removed from patients who had suffered from violent pruritus, that the enlargement concerned the connective tissue layers, and the nerves therein lying, the latter being three or four times greater than normal.

GANGLIAR DISEASE OF JOINTS.

IN the *British Medical Journal*, for August 30, MR. A. T. NORTON calls attention to a hitherto undescribed destructive disease of joints, which resembles in external appearance, and often in its symptoms, scrofulous disease and rheumatic disease. It is associated with the presence of ganglions in the adjacent tendons, and the ganglions may or may not be connected with the articulation.

Gangliar disease of the joints is essentially a chronic affection, extending frequently over ten to fifteen years, and occurs almost invariably after the thirty-fifth year, elderly persons being most liable to it. It arises spontaneously, the affected joint is not tender to the touch, nor accompanied by much pain, although there is often aching, when the patient refuses to use the limb. With the progress of the disease, the joint becomes useless, the ligaments give way, and, in the case of the wrist, there is a lateral gliding motion, and the hand hangs and cannot be lifted. When the bones ulcerate and suppuration is established, pain and elevation of temperature are superadded.

The disease invariably terminates in ulceration of the bones, preferably those of the carpus and tarsus, which progresses very rapidly until all the separate pieces are affected, and some completely disappear. The synovial membrane is villous or granular, the joint is distended with fluid, and there is always associated gangliar disease of the tendons, the cyst being filled with the usual gelatinous material and melon-seed-like bodies.

The presence of ganglions suffices to differentiate the affection from common ulceration of the cartilages, or from rheumatic disease. In strumous synovitis the swelling is fluid, and not solid to the touch, as in gangliar disease. In diagnosticating from

rheumatism, the enlarged bursæ which occur in that affection must not be confounded with ganglions.

The treatment is not satisfactory, as the disease is progressive. In the early stages, the ganglions and joint may be aspirated, and the limb may be fixed upon a splint, and discutient lotions be applied. When, however, the hand hangs, or the joint glides, amputation is demanded.

MISTAKES IN PROPER NAMES.

A FEW weeks ago we read in one of our contemporaries a severe criticism of the rhetorical and grammatical errors not infrequently found in our American medical journals. Unfortunately for our faith in the knowledge and accuracy of the critic, we found on another page an editorial quotation from "Sir Thomas Brown." Now, although there have been two famous British subjects of this name,—not to mention "Tom Brown at Rugby,"—neither was knighted, nor made a baronet. Sir Thomas Browne, one of the most eminent of physicians in his day, and one of the most learned and brilliant writers of his century, surely attained sufficient fame to have his name correctly spelled, above all by one who assumes the functions of a medical critic.

Mistakes in names are by no means uncommon in medical writings, and illustrations meet us both in home and in foreign productions. We have just read a paper by an eminent Boston physician in which the weird musical dream of Coleridge, *Kubla Khan*, is attributed to Carlyle. One of our Irish cousins is the author of a recent book on diseases of women, in which he refers to "Ambrose Pallen." There was an Ambrose Paré, and there is a Montrose Pallen, and justice requires that each should have his own name.

One of the most eminent of American gynecologists has more than once appeared in French writings with the Tartarean name Goodhell, and quite recently we read in a German obstetric work that a Detroit physician named "Jenkins" advised viburnum prunifolium in threatened abortion.

Sirèdey, in his recent work upon puerperal diseases, referring to the great mortality from childbed fever in the practice of the late Dr. David Rutter, then living in Philadelphia, remarks: "During the same time his *confrères*, Sir William Klame and Dr. Meigs, among others practising in the same city, did not have a single case of the disease." William Klame is a poor substitution for William Klapp, and it is not compensated for by the title of nobility which precedes it.

Charpentier classes Mundé among German authorities, just as some others have enumerated Fordyce Barker among Englishmen, and a well-known Philadelphia surgeon recently appeared in a French periodical as Dr. Gohnpackard.

SPECIAL ARTICLE.

INTERNATIONAL ELECTRICAL EXHIBITION, PHILADELPHIA.

[FIRST NOTICE.]

THE medical public have no doubt anticipated that in this great exhibition of electric appliances would be found the latest and most valuable of therapeutic and experimental instruments; and that this display of inventive genius would, perhaps, be the incentive to or the suggestion of still other new or improved instruments for physiological investigation and for the discovery and cure of disease. We are sure that these anticipations have not been in vain. The Directors of the Franklin Institute, under whose auspices the Exhibition is held, have wisely offered every inducement for the display and comparative test of all the different electrical machinery and appurtenances in which physicians are specially interested.

The collection of instruments of precision, as used now in the mechanical arts and in commerce, is very large and fine, and it must certainly offer to the electro-therapeutist some suggestions whereby he may improve his own work. The Exhibition, it seems to us, promises light especially in two departments of medical research, viz., physiology and therapeutics. When we say light, however, we ought perhaps say the sources whence light comes, for it must be remembered that the tools only are shown, and not the cunning workman who will make them do his will. In other words, we have a show of instruments, not a laboratory of experimenters. It is the object of the managers to have practical tests made by the Board of Examiners of the exhibits, the results of which tests will be embodied in a subsequent report. This will be a work of some magnitude, and the book no doubt will have high scientific value; but our readers can readily understand that in this paper we can only indicate the uses of exhibits, and not always, perhaps, vouch for results. In dentistry, also, there will probably be a handsome and unique display; while electric lighting will be utilized for surgical work in the various cavities of the body and for illuminations in microscopy.

In physiological invention the French have a deserved reputation, and their name is synonymous with elegance of workmanship as well as accuracy and ingenuity in the application. They have naturally turned to electricity to assist them in their delicate devices, and we expect a display from some Parisian workshops to which we will be largely indebted to Mr. Queen, of the Philadelphia importing house. We have had as yet but a glimpse of these instruments, which are still piled up in a sort of chaotic confusion in their showcases, but shall refer to them more in detail hereafter. They include cardiphones, myophones, laryngophones, and numerous *et cetera*, whose exact mechanism we could not master with only such assistance as a busy and harassed attendant could give us. This firm also exhibit large and powerful Toepler-Holtz machines. In therapeutics and diagnosis it is probable that the physician will derive advantage from the Exhibition, especially on the subject of tests and measurements. We have considered this to be a great desideratum in the work of the electro-

therapeutist, as for exact results nothing would seem more important than to take accurately and easily in known standards the varying resistances, for instance, in different patients and limbs, and in the same patients and limbs at different times. Certainly good test instruments are not a common appendage to the ordinary medical battery. This venerable machine, as ordinarily used, is filled up, the switch turned, the patient electrified, and all is over.

We have been disappointed, so far, in finding among the medical exhibits not much, if any, evidence of even a commercial interest in such matters—and the commercial interest of an instrument-maker is a very good gauge of the scientific interest of the surrounding doctors. It is not so in the general electrical world at the big building. Among the finest displays, both pleasing to the eye and stimulating to the thirst for knowledge, are the elegant test instruments shown by several electrical supply companies. These are very elaborate, very expensive, and very delicate, and thus far we are impressed with the idea that very few of them are adapted either in price or adjustment to medical wants. Do we need such an exact galvanometer as measures to the one ten-thousandth of an ohm; or an ammetre that will measure a current of a hundred ampères; or a set of resistance coils that cost three hundred dollars?

In closing this preliminary notice we are compelled to express our regret that a few exhibitors of a doubtful character have been allowed to have space on the floors of this scientific exhibition. For instance, we notice that one of the merest traders in "Electropathy" has hung up, in a corner, to be sure, his sign announcing "The blood is cleansed by electricity only!" Here he dispenses the mystic fluid along with blue and yellow advertisements that cancer and consumption can be cured. He is aiming at business—but he has no business there. More innocent, because less deluding, is the little showcase of metallotherapy mysteries—beautiful pink-embroidered braces, and belts, and chest-protectors, fit for the finest lady in the land, and calculated, no doubt, to win some of them.

We close with the confession that we have swung the electric dumb-bell, which conceals in its innermost depths a small bisulphate of mercury cell, and as one swings it about his neurasthenic brain he feels the faradic impulses awakening his periphery.

REVIEWS.

A SYSTEM OF HUMAN ANATOMY, INCLUDING ITS MEDICAL AND SURGICAL RELATIONS. By HARRISON ALLEN, M.D. Section VI., Organs of Sense, of Digestion, and Genito-urinary Organs. 4to. pp. 585–812. Philadelphia: Henry C. Lea's Son & Co., 1884.

THIS is the last part of Allen's Anatomy. It completes a work of unusual magnitude, especially on this side of the Atlantic, and a work unique in its design in anatomical literature. Not but that many authors have here and there added random clinical notes, especially in works on topographical anatomy; but in this book the relations of every part to disease have been the systematic and pervading purpose of the work. Whether this clinical relation spring from form or structure, or function or development, or position, the accomplished author has, as a rule, seized upon the salient facts and has stated them clearly and illustrated them by copious citations of cases from the most widely diverse sources.

We are glad to see that in his preface, which is furnished with this part, he expresses his high appreciation of the Library of the College of Physicians of Philadelphia. This is second only to the National Medical Library in Washington, and has reached a size and value that make it now a necessity to any one who is working upon any subject where literature has to be studied. Its liberal management is exceedingly commendable. If now the Library of the Pennsylvania Hospital could only be consolidated with it, what a truly splendid collection they would make!

The title-page of this Section only partly expresses its contents, for there are added to it also chapters on Superficial and Topographical Anatomy, Embryology, Malformations, and Post-mortem Examinations. Each of these subjects receives a fair share of attention, yet it is evident at a glance that no one of them can be more than briefly treated in the limits assigned to it. But each will give to many readers a clear view so far as it goes, and whet the appetite for fuller works.

The clinical remarks are in general excellent and valuable. In the remarks on the teeth we are surprised however to see nothing as to dental syphilis—the most important, perhaps, of all their clinical relations. Nothing is said under the soft palate of the author's ingenious researches on the movements of the soft palate in voice. Although the clinical results of these studies are as yet hardly appreciated, yet a less modest writer would certainly have included them.

The woodcuts are excellent, and the lithographic plates are far better than the earlier ones. But they are still scarcely satisfactory, and are defaced with some errors that are to be regretted in so admirable a work. We observe errors of spelling in Plates 93, 98, 99, 103, 101, etc. The publisher's part of the work could not have been more liberally and finely done. We take leave of the work with a high opinion of its merits, and commend it to the generous patronage of the profession. Few medical men will read a page without learning or recalling some valuable fact.

BALDNESS AND GRAYNESS: THEIR ETIOLOGY, PATHOLOGY, AND TREATMENT. By TOM ROBINSON, M.D. Second edition, enlarged and rewritten. Duod. pp. 139. London: Henry Kimpton.

THAT this book has filled a generally felt want, seems apparent to the author from the fact that it has come to a second edition within eighteen months. To ourselves this want seems to have been most strongly felt by the bald and gray, of whom there are, alas, too many amongst us, since Dr. Robinson's book appeals to the external, rather than to the internal portion of the cranium. In other words, with the usual farrago of learned remarks about the true skin and the scarf skin, etc., and the array of unverifiable and vague quotations which we are accustomed to meet with in treatises of this kind, we find that but little accurate information regarding the physiology and pathology of the hair, and not much of value regarding the treatment of its diseases. The work seems to be written rather for the layman than for the practitioner.

SOCIETY PROCEEDINGS.

MEDICAL SOCIETY OF VIRGINIA.

Fifteenth Annual Session, held at Rawley Springs, September 9, 10, and 11, 1884.

(Specially reported for THE MEDICAL NEWS.)

TUESDAY, SEPTEMBER 9TH—FIRST DAY.

THE fifteenth annual session of this State Society convened at Rawley Springs, Rockingham County, at 8.30 P.M. By the invitation extended last year by the Managers of these Springs, the Society was entertained as their guests. There were about one hundred and thirty members present.

THE PRESIDENT, DR. J. E. CHANCELLOR, of Charlottesville, called the session to order, and Dr. M. G. Ellzey, of Washington, D. C. (who is the Summer Resident Physician at these Springs), delivered an *Address of Welcome*, which not only imparted some local information, but also conveyed a cordial greeting.

The President introduced DR. ROBERT I. HICKS, of Casanova, Fauquier County, Va., who read the Address to the Public and the Profession, entitled

HYGIENE IN RELATION TO THE PRIVATE FAMILY.

He began by showing the important relation existing between individual sanitation and the public health. He briefly described the investigations of Pasteur, Davaine, and Koch in connection with the germ theory; explaining the microbes, bacilli, vibrios, and spores found by these observers in different forms of disease, and suggested that his hearers be not too ready of belief as to these microörganisms producing disease, as they may be simply accompaniments of the disorders named. After this question is settled, there remains the most important thing to be done, *i. e.*, how best to destroy them. He enumerated the different abiding places of these germs, and showed that by destroying the conditions of their existence we destroy them.

WEDNESDAY, SEPTEMBER 10TH—SECOND DAY.

MORNING SESSION.

Upon call for reports on advances in the different departments of medical science,

THE REPORT ON ANATOMY AND PHYSIOLOGY

was read by Dr. L. B. Edwards for DR. HUGH T. NELSON, of Charlottesville, Va., who was unavoidably detained at home. In the *blood*, he stated that a third blood-corpuscle or hæmatoblast had been discovered by Bizzozero, of Turin, which observation had recently been confirmed by Leker and Fred. Rauschenbach. It is a disk with either parallel or biconcave surfaces, one-third smaller than the red corpuscles, and ranking in number between the red and white disks. Their function is seen in their coagulation, which was formerly attributed to the white corpuscles. They play an important part in thrombosis and embolism, in septic fevers, and in operative surgery. They are especially abundant in cachectic and in anæmic blood.

In regard to *digestion*, Poehl found that all the tissues of the body possess some peptic power, and suggests that the ferment in the lung tissues dissolves and digests the fibrinous exudation of croupous pneumonia. Poehl maintains that gastric or tryptic digestion is simply a soaking of the albumen with water to its utmost capacity, and that the different forms of albumen are digested in proportion to the rapidity with which this absorption of water takes place. Peptone, then, is a modification and not a decomposition of albumen. Hence peptonized foods are fast superseding the use of meat extracts in practice.

Dr. Nelson thought the day near at hand when practical benefits would result from the study of *cerebral localization and cerebral nerve-tracts* which is now being carried on by competent workers. Valuable statistics, showing the use of the trephine in traumatic epilepsy, were given. Charcot and Pitres's investigations as to the locations of the motor and non-motor zones were mentioned. The conclusion is arrived at that the *visual area* lies in the occipital lobes. *Auditory impressions* are received by the first temporal convolutions on the right side for the left auditory nerve, and *vice versâ*. The power of *recognizing words* is located in the first left temporal convolution in right-handed persons, and *vice versâ* for left-handed persons. *Odors* impress the temporo-sphenoidal region of the base of the brain. The *taste* centre is not yet located. The sense of *general sensation* is located in the cortical cells of the central convolutions, and in those parts of the parietal convolutions adjacent to the posterior central convolution. The centres presiding over *articulate language* are in the convolutions about the fissure of Sylvius—the left side in right-handed persons, and *vice versâ*. The *ideo-motor power* resides in the third frontal and adjacent part of the anterior central convolutions. Next, it was shown that there exist direct nervous tracts between the cortex cerebri and both motor and sensory nerves, and a system of nerve-tracts in connection with the optic thalamus. A system of nerve-fibres pass from the cortex cerebri to the gray centres of the pons. Several distinct nerve-tracts are also found in the tegmentum of the crus cerebri, lying beneath the corpora quadrigemina.

DR. WM. C. DABNEY, of Charlottesville, Chairman of the Committee on Medical Legislation, reported that, aided by Mr. John B. Moon, of the House of Delegates of Virginia, and Senator Trout, of Roanoke, a bill was enacted which, while not entirely satisfactory, provides for

A STATE BOARD OF MEDICAL EXAMINERS,

before which every applicant for practice after January 1, 1885, must pass a satisfactory examination before receiving a license to practise medicine or surgery. Two examiners at large are to be elected by the Society, as also three from each of the ten electoral districts of the State. A fine of $500 is to be imposed upon those who do not comply with the terms of the law.

AT 11 A.M., DR. J. EDGAR CHANCELLOR, of Charlottesville, proceeded to deliver the

ANNUAL ADDRESS OF THE PRESIDENT.

After a few pleasant introductory remarks, congratulating the Society upon the growing interest manifested in the annual meetings, by the increased attendance and the character of the papers presented—he alluded to the progress made since the last meeting in securing

a partial recognition of the rights of the profession, by legislative enactment in the passage of the Anatomy Bill and the Act establishing a State Board of Medical Examiners by the Legislature of Virginia. But he said that, as gratifying as this may be, there yet remained much to be done.

With his greeting was mingled the sad duty of bearing to the Society the tidings of death's doings among the membership during the present year, stating that it had been a year of unusual mortality among the older members especially. Some six or eight of the charter members had died, and several of the younger Fellows. Among these were three ex-Presidents, one a distinguished teacher of the Medical College of Virginia.

He then passed to the consideration of his subject—*Origin and History of Ancient Medicine.* He took up the history of those men who were most prominent in the practice of medicine under the different systems and schools of medicine, remedies, etc. He then referred to the importance of proper organization, and of selecting proper persons who are to constitute the Board of Medical Examiners for the State. He urged that it should be an independent body, and thought that no person directly or indirectly connected with a medical institution should have a place upon the Board. He did not consider the bill establishing the Board of Medical Examiners perfect, though a great advancement in the right direction, and advised the appointment of a committee to examine and, if necessary, recommend amendments, etc.

DR. JOSEPH A. WHITE, of Richmond, presented a volunteer paper on

NASOPHARYNGEAL OBSTRUCTION AND HYPERTROPHIES IN THEIR RELATION TO HEARING.

Dust, such as arises from the macadamized streets of our cities, is one of the most active and prolific causes of nasopharyngeal irritation. Changes of climate, and moisture in winter, are also special irritants that bring about catarrh and hypertrophies of the membrane lining the nose and nasopharynx. His experience bears out the assertion that deafness is a frequent result of vegetation in the upper pharynx. After some minor suggestions, he said that all cases of middle-ear disease, whether acute or chronic, are accompanied, more or less, by nasopharyngeal changes. And every case of nasal obstruction resulting in mouth-breathing, and all cases of obstruction of the lower nasal meatus, even where the air current can still pass through the upper passages, will, sooner or later, become more or less deaf, if the obstruction is allowed to remain. He remarked that posterior rhinoscopy is not of much service in little children, but the *tactus eruditus* is of great value. Put one arm around the child's neck, with the fingers on the cheek so as to prevent biting of the examining finger by pressing the soft tissues of the cheek between the teeth. Then pass a finger up behind the uvula and explore the post-nasal cavity. Vegetations feel like a bunch of worms; hypertrophies are smooth and hard. In adults, if there is difficulty in examining, he passes a No. 1 bougie, with a small-sized piano-wire inside, along the lower nasal meatus into the pharynx, and draws it out of the mouth, in the same way that Bellocq's canula is used. Then tie the two ends of the wire together over the upper lip, or draw a small tape through, and by means of this forward traction of the soft palate one gets a fair view of the nasopharynx.

Anterior hypertrophy of the turbinated tissues can be removed by the cold snare or by galvano-cautery. Glacial acetic acid applied to the surfaces, with intervals of several days, is often successful. Chromic acid is also used in the same way. Sometimes these hypertrophies subside spontaneously, especially if in connection with posterior hypertrophies.

Nasal polypi, if large, can be removed by the snare; but when small evulsion is the best method, and the points of origin touched with chromic acid or the galvano-cautery.

Deflection of the septum, if slight, should be left alone. If sufficient to cause stenosis, any accompanying hypertrophies should be removed or destroyed, and the deflected portion perforated and forced back into position by clamp forceps and plugs, or by flat laminaria tents.

Outgrowths from the septum can be cut off by the bistoury or snare. Counter applications are not serviceable.

Hypertrophy of the pharyngeal tonsil can be removed by the cold or hot snare or by the cutting forceps, or by burning with the galvano-cautery.

Posterior hypertrophy of the turbinated tissues is best removed by the wire snare or by the galvano-cautery.

Chromic acid is the best of the chemical cauteries. It destroys the tissue to which it is applied without "running." Warm water instantly relieves any pain it may cause, especially if associated with bicarbonate of sodium. Poisoning from its use is easily prevented by douching the parts with warm water as long as the water becomes tinged by the acid. Of course, warn the patient not to swallow.

Anything that produces an ulceration of the mucous membrane over the septum will produce perforations because the cartilage receives its nutriment from its mucous covering, but the perforation is limited in extent. If workmen would wear wool pellets in their nostrils, they would not suffer so much. In fact, all persons, working in dusty or "fumy" places ought to wear wool or cotton loosely packed in their nostrils during the hours of their work. He opposed the view of Dr. Donaldson, of Baltimore, as to the value of chromic acid in cases of hypertrophy of the tonsils, unless the hypertrophy was soft and yielding. In *dense* hypertrophy of the tonsils, extirpate.

AFTERNOON SESSION.

The order of business being the

ELECTION OF OFFICERS,

much discussion occurred as to the manner of entering upon the task.

By large majorities, and, in some instances, by unanimous vote, the following officers for the ensuing year were elected:

President.—Dr. Samuel K. Jackson, of Norfolk, Va.

Vice-President.—Dr. Jesse Ewell, Sr., of Hickory Grove, Prince William County; Dr. Benjamin Blackford, of Lynchburg; Dr. R. I. Hicks, of Casanova, Fauquier County.

Recording Secretary.—Dr. Landon B. Edwards, of Richmond.

Corresponding Secretary.—Dr. Hugh M. Taylor, of Richmond.

Treasurer.—Dr. R. T. Styll, of Richmond.

EVENING SESSION.

The Society convened at 8 P. M. It was engaged from this hour until nearly 2 A. M. in electing members of the

STATE BOARD OF MEDICAL EXAMINERS.

First District.—Drs. S. W. Carmichael, of Fredericksburg; O. B. Tinney, of Onancock; W. W. Douglas, of Middlesex County.

Second District.—Drs. Thomas B. Ward, of Norfolk; L. Lankford, of Bowers, Southampton County; Jesse H. Peek, of Hampton.

Third District.—Drs. R. A. Lewis, of Richmond; Charles R. Cullen, of Richmond; O. A. Crenshaw, of Richmond.

Fourth District.—Drs. William J. Harris, of Nottoway; Hugh Stockdell, of Petersburg; J. Herbert Claiborne, of Petersburg.

Fifth District.—Drs. W. L. Robinson, of Danville; T. B. Greer, of Rocky Mount; and Rawley W. Martin, of Chatham.

Sixth District.—Drs. Harvey Black, of Blacksburg; H. Gray Latham, of Lynchburg; and Oscar Wiley, of Salem, Roanoke County, Va.

Seventh District.—Drs. William P. McGuire, of Winchester, Va.; J. H. Neff, of Harrisonburg; Hugh T. Nelson, of Charlottesville.

Eighth District.—Drs. C. C. Conway, of Rapid Ann Station; Bedford Brown, of Alexandria; and Alex. Harris, of Jeffersonton.

Ninth District.—Drs. S. W. Dickinson, of Marion, Smyth County; Robert J. Preston, of Abingdon; and R. D. Huffard, of Chatham Hill.

Tenth District.—Drs. Henry M. Pattison, of Monterey; Z. G. Walker, of Gishe's Mill; and —— Merriwether.

(To be concluded.)

CANADA MEDICAL ASSOCIATION.

Seventeenth Annual Meeting, held at Montreal, August 25, 26, and 27, 1884.

(Specially reported for THE MEDICAL NEWS.)

AUGUST 25TH—FIRST DAY.—MORNING SESSION.

THE first general meeting took place at 10.30 A. M., when Dr. Mullen, of Hamilton, Ont., the retiring President, introduced DR. SULLIVAN, of Kingston, Ont., the PRESIDENT-ELECT.

DR. HINGSTON, Chairman of the Committee of Arrangements, welcomed the Association on behalf of the profession of Montreal.

The meeting was the largest which the Association has held for some years, and a number of the medical members of the British Association for the Advancement of Science took part in the proceedings. Among these were Mr. Lawson Tait, of Birmingham; Drs. King and McMillan, of Hull; Drs. Gaye, John Wood, John Harley, Protheroe Smith, Heywood Smith, and Hack Tuke, of London; Prof. J. D. Cunningham, of Dublin; Prof. Struthers, of Aberdeen; Dr. Alexander, of Halifax; and Prof. McKendrick, of Glasgow.

Among the American visitors were Drs. Bowditch, of Boston; Brodie and McGraw, of Detroit; Brush, of Utica; and Murphy, of Kansas City.

The morning session was occupied with routine work, and with the reception of reports of committees.

AFTERNOON SESSION.

At 2 P. M., the PRESIDENT delivered

THE ANNUAL ADDRESS.

After thanking the members for having placed him in such an honorable position, he proceeded to give an account of the organization of the Association eighteen years before, at the time of confederation of the provinces, and spoke of the benefits which had resulted to the profession.

SURGICAL SECTION.

DR. RODDICK in the Chair. The first paper was read by DR. BLACKADER, of Montreal, on a

CASE OF CONGENITAL HYPERTROPHY WITH LIPOMA OF THE FOOT.

In this case there was also local hypertrophy of the parts in immediate juxtaposition to the lipoma. The literature upon this subject is not extensive, but Curling, Reid, and Wagner have reported cases, and Dr. Wm. Anderson, of St. Thomas's Hospital, has, with his case, given a *résumé* of our knowledge upon the subject up to date. The growth might be defined as a gigantic hypertrophy of the various segments of the body, exclusive of the viscera, unilateral, usually implicating the bony and integumentary structures, and generally associated with lipoma. The growth does not, as a rule, impair the functional activity of the parts involved, and in most cases might be relegated to a status lower than that of true hypertrophies.

No exciting cause can be given. Mental impressions upon the part of the mother during gestation, are quoted as being such, but Anderson fancies them to be mere coincidences. The extent of the growth may vary, and involve only a single digit, or, on the other hand, one-half the body. It does not appear to be limited to vascular or nervous territories.

The growth is painless. Anderson divides these hypertrophies into true and false. The first class is a small one, and includes those cases in which all the structures of the part are involved. The second or larger class includes all cases in which the hypertrophy involves one or more of the structures of a part, leaving the rest, it may be, in a natural condition. Practically, we may divide our cases into those with or without deformity.

The pathology of the subject is obscure. Partial intra-uterine strangulation has been suggested; stagnation of lymph has also been suggested. In the lipomatous form the altered nutrition is due to lymph stasis, while the hypertrophy is due to an augmented venous supply.

The one condition necessary for their production is an interference with the flow of lymph due to absence of the valves, ectasia, or other cause. The shape is irregular, as a rule. The locality varies, only one having been noticed upon the head; a common seat of election is the lumbar and gluteal regions, commoner still is the hand.

The *history* of the case before the meeting was as fol-

lows: In March, 1883, delivered Mrs. S. of her fourth child; confinement normal in every way; child heavy and well-formed, except as regards the left foot. The legs and thighs were the same in size and form, but the anterior half of left foot presented a smooth and elastic tumor, large and well rounded. The second and third toes were webbed and projected half an inch beyond the great toe; there was no tenderness or increase of temperature in the part, but movement was deficient. In a month it had increased in size, so a Martin's India-rubber bandage was applied for the sake of continuous pressure. This irritated the child, so the mother discontinued its use, and Dr. Blackader did not again see the child till January, 1884, when Dr. Fenwick was called in consultation and advised a renewal of the former mode of treatment. This giving no relief, an operation was performed by Dr. Roddick.

Before the operation, the heel was noticed to be enlarged. From the centre of the plantar surface the tumor arose as before described. The great toe was not enlarged, but the little toe was twice the size of the corresponding toe of the opposite foot. No apparent affection of either the lymphatic or venous systems was noticed. The second, third, and fourth toes were removed, and the anterior two-thirds of the corresponding metatarsal bones also. The operation was done with antiseptic precautions; no rise of temperature followed, and on the tenth day the stitches were taken out. Upon examination of the bone removed, the epiphyses were seen to be enlarged, but the diaphyses were not affected to any extent.

DR. KERR, of Winnipeg, mentioned the case of a child four years of age, who is now under treatment, and has had the disease for three years. The child has only been under observation for nine months, but in that time no increase in growth has been noticed.

DR. OSLER had also seen a case a few years ago in which there was general and progressive enlargement of the right upper limb—bones, muscles, and fingers all being enlarged. The pad of the hand was especially enlarged, due to increase in the amount of fat. The grip of that hand was much more powerful than that of the other. He asked Dr. Blackader if, at the time of operation, the muscles were seen to be hypertrophied.

DR. MCGRAW, of Detroit, gave the details of a case which he had seen in Langenbeck's clinic in 1861. This was the case of a girl, aged sixteen, in whom there was enlargement of the left lower extremity, and left side of pelvis. All the structures of the limb were immensely enlarged, especially the bones; and the weight of the limb was such that the girl could not walk. No complication with any tumor was noticed.

DR. BLACKADER, in reply, said that the cases quoted by Dr. Osler and Dr. McGraw belonged to Anderson's division of true hypertrophies. His own was a case of false hypertrophy, the muscles not being enlarged, and the tissues composing the enlargement being of the nature of a true fibroid lipoma, the bones, ligaments, and fatty tissues being alone hypertrophied.

DR. PROUDFOOT, of Montreal, exhibited a case of

SYPHILITIC ULCERATION OF THE SOFT PALATE AND PHARYNX.

Disease began in the cartilaginous septum of the nose, and thence extended. The chancre occurred five years previously. In answer to Dr. Sullivan, Dr. Proudfoot detailed his treatment of the case, viz., ⅛ gr. of bichloride of mercury, in conjunction with iron and ammonia, three times a day. Dilute hydrochloric acid was used topically.

DR. FULTON, of Toronto, then read a paper on

THE THORACO-PLASTIC OPERATION OF EASTLNDER.

The paper was confined to the treatment of empyema. Resection of a portion of a rib for the evacuation of pus has long been practised, but Estlander by his method tried to obliterate the suppurating cavity and cause occlusion of the pleural fistula. Of 50 cases reported by Dr. Colman in which the ordinary method of treatment by incision, drainage, and disinfection of cavity was practised, 50 per cent. recovered, 33 per cent. died. and in 17 per cent. of the cases the fistula remained. The fistula usually results from the formation or existence of a cavity between the thorax and lung, lined by pyogenic membrane.

The size of the cavity varies indefinitely, as does also the amount of discharge. A slight but long-continued discharge is dangerous, as amyloid or tuberculous disease may follow. The rationale of Estlander's operation is to remove a portion of one or more ribs, and let the chest-wall sink, so as to allow of the layers of pleuræ coming in contact.

The following case was then narrated. M.B., aged 28, came under Dr. Fulton's care in November, 1883; personal and family history good. During May and June of the year 1882, patient's chest had been aspirated for accumulation of fluid, and serum removed. In June of 1882, pus was found, and from that time on till July, 1883, the discharge continued, and the cavity was washed out regularly with salicylic acid. Upon admission patient was found to be spare and anæmic, with slight hectic; in the axillary line between the seventh and eighth ribs of the right side the opening was situated. The left lung and upper portion of right lung was normal.

The discharge averaged about an ounce daily and the cavity was regularly washed out, but no improvement being noticed, an operation was decided upon and performed as follows: An incision five inches long was made in the side of the chest, and parallel to the sixth and seventh ribs. The periosteum of the rib was divided and raised on each side, and three inches of the rib removed. The upper margin of the wound was then raised, and a portion of the sixth rib was removed in like manner. The slight hemorrhage was arrested by torsion, the cavity was washed out with carbolic acid lotion, and a large drainage-tube was inserted. The temperature rose but slightly and recovery was uninterrupted. The cavity was washed out daily with carbolic acid and tincture of iodine, and the patient left the hospital March, 1884. She has now improved in general health, the cavity is gradually closing up and Dr. Fulton thinks that within a month the drainage-tube may be discarded. The ends of the resected ribs can be felt, but the space between feels firm, and osseous deposit is no doubt taking place.

Dr. Fulton thinks that the operation is indicated in chronic cases of empyema which have resisted ordinary methods of treatment for some time; also in cases in which a fistula has remained for five or six

months, and in which there are no signs of tubercle or albuminuria. Estlander has performed the operation with success in delicate subjects and under the most adverse conditions. The incision must depend upon the situation of the cavity and position of the fistula, but the lateral situation is best. Portions of two, three, four, or even six ribs may be resected, but for obvious reasons no interference is permissible with either the first, second, eleventh, or twelfth ribs. There is usually but little hemorrhage, and the woudd is easily united, drained, dressed, and dried. In some cases an elastic bandage about the chest has aided in occluding the cavity.

DR. HINGSTON, of Montreal, thought the subject of operating in empyema a difficult one, for two cases are seldom seen exactly alike. He thought that Estlander's operation would be more successful if portions of more ribs were removed to a less extent. He has found that in many cases the excision of one or two ribs has had no effect in aiding the occlusion of the cavity. If the operation be thought of, he would not advise haste, for he considers it a serious operation, and has often had cases heal in from twelve months to two years, after thorough and regular washing out of the cavity. Of course, if the health of the patient be giving way, we might interfere at once.

DR. KERR gave a short account of a case which he had seen in consultation. It was one in which a free incision had been made; the patient was then sent to the seaside, and her general health attended to. On her return the extent of secreting surface appeared to have diminished, for the discharge had lessened materially.

DR. HOLMES had had no experience with Estlander's operation, but has drained, and he thinks that if cases of empyema were earlier treated, less disastrous results might ensue. He thinks that the slow obliteration of the cavity is often due to the fact that pus has remained in the cavity for a long time, and by its presence has, in some way or another, interfered with the vitality and tone of the membrane.

DR. RODDICK spoke of the treatment pursued in the Montreal General Hospital. A single opening is made, portions of the ribs may be removed, and a large oval metallic drainage-tube is then introduced one-half to three-quarters of an inch. The cases are treated with antiseptic precautions, the spray being used; but in the after-treatment injections are not used too often. For injection the solutions of boracic and salicylic acids are now used instead of carbolic acid. He has never needed to remove more than a portion of one rib. In children, he has found repeated aspirations all that are needful.

DR. SHERRIFF, of Huntingdon, described

A NEW METHOD OF TREATING HEMORRHOIDS BY CRUSHING,

as performed by Mr. Pollock, of St. George's Hospital, London, and as related by him in *Braithewaite's Retrospect*, for January, 1881. Dr. Sherriff gave the details of the case of a man, aged thirty-five, who had suffered long from hemorrhoids, and in whom Pollock's method was followed. There was no hemorrhage, patient was well in a few days, and when last seen, two and a half years since the operation, had had no return. The sudden destruction of the parts by crushing does away with the hemorrhage and pain, hence he thinks that general anæsthesia is not necessary in all cases.

DR. HINGSTON thought the instrument shown by Dr. Sherriff a good one, but was afraid that if too much be removed at one sitting stricture would be apt to follow. He instanced a case in point, in which a stricture occurred after the removal of the hemorrhoids by the écraseur; it was the worst stricture he had ever seen, and was not amenable to treatment. He suggested that only one-half of the bowel be treated at once. Dr. Hingston uses the écraseur; seizes the hemorrhoid by a pair of Péan forceps, slips the écraseur over those caught, and then works the instrument quickly.

DR. TYE, of Chatham, thought but little trust should be placed in topical applications. He has used the ligature and Smith's clamp and cautery, but since reading Pollock's paper, has used a pair of blunt scissors for crushing purposes, with after-use of the cautery.

DR. RODDICK thought that the use of Smith's clamp and cautery gives the best results. For the last eight years he has done that operation exclusively, and without a single bad result. He uses the thermo-cautery instead of Smith's irons. He removes the piles freely with the curved scissors, leaving about one-eighth of an inch in the grasp of the clamp. He has had no hemorrhage, and never a case of tetanus. In compound cases he dissects the pile out by an elliptical incision, suturing and dressing with iodoform, and does not clamp in these cases.

DR. TAYLOR has used injections with great success, using for the purpose 1 part of carbolic acid to 10 parts of glycerine.

EVENING SESSION.

DR. FENWICK, of Montreal, read a paper on

ABSCESS OF ABDOMINAL PARIETES EXTENDING FROM MECKEL'S DIVERTICULUM.

This was the case of a girl, aged twelve, of full development, who suffered from an abscess in the abdominal parietes, situated below the navel and to the right side. The abscess was opened, and pus and what appeared like grumous blood escaped, but not in very large quantity. The abscess continued to discharge for several months, the opening decreased, but a sinus was left leading downwards from the umbilicus to the right side, four inches in length. On the 25th of April, 1882, the sinus was slit up, and in a month, when the sinus was nearly closed, the child went home, and by the middle of June it had completely closed.

The girl being active and fond of exercise, ran about a good deal, and the abscess reformed. This was treated by poultices, and in a few days it burst and began discharging. In October, Dr. Fenwick again saw her and found a sinus as before, which he again slit up. In February, 1883, another abscess formed, which was treated in the same manner by the local surgeon. Toward the end of 1883 the same trouble recurred, and a sinus was again left. This time the physician in charge dilated the sinus by sponge-tents. On the 11th of May, 1884, the girl again came under Dr. Fenwick's care, and while examining the case next day, feces were noticed mixed with the pus, and Dr. Fenwick then thought that the abscess must be in communication with the intestine. In consultation with Dr. Roddick, it was decided to operate, and on the 16th of May the abdomen was opened, under antiseptic precautions, by

an incision four inches in length, extending downwards from the umbilicus in the median line. Upon examination a blind duct was found attached to the abdominal wall, and at the extreme end of the diverticulum a hard mass or concretion was found. The diverticulum was separated from the abdominal wall, and it was then found that its extreme end was open and in direct connection with the sinus in the abdominal wall. Through this opening a fine probe could be passed. The end of the diverticulum was opened, the concretion removed, and the free end sutured with catgut, that had been soaked in chromic acid. After closing all bleeding points, the abdominal parietes were brought together and a drainage-tube introduced. The case progressed slowly but favorably till the middle of June, when diarrhœa and vomiting came on. The stomach was so irritable that rectal alimentation had to be employed. There was high fever, pulse wiry, etc., but on the 16th of June a change for the better took place, the temperature fell and the pulse became normal. On the 12th of July the patient left her bed and in a couple of weeks returned home. The diverticulum appeared to be from six to eight inches long, it was attached to the small intestine and passed directly upwards and backwards from its attachment to the abdominal wall. It consisted of all the intestinal coats, serous, muscular, and mucous, and had a portion of mesentery attached to it. Since her return home, the parents have written to say that the girl is gradually improving in general health. The concretion removed appears to be a mass of hardened feces, encrusted with phosphate of lime.

DR. R. P. HOWARD, of Montreal, had seen the patient with Dr. Fenwick. He recently was consulted by a young man for acute inflammation about the umbilical region. Matter was being discharged and the navel itself was granulating and discharging pus. The induration was deep in the abdominal parietes, but as the exact seat could not be exactly made out on account of the thickness of the walls, he advised the patient to go to bed for rest, and to apply poultices. In a few days a small concretion about the size of a bean was extruded during attempts to press out the matter, and the patient said that five such had passed before. Since that time the patient has entirely recovered. Dr. Howard thought that in this case there was a connection with the bowel, probably through the remnants of the umbilical duct, which had remained patulous; a foreign body had lodged in it, irritation and inflammation were set up, and an abscess formed.

DR. KING, of Hull, England, in connection with the above cases, mentioned a species of abscess which began as a hard deep-seated swelling, making it difficult to tell whether intra- or extra-abdominal. He thinks they probably begin in the muscles, and as they form sink toward the inguinal region, where they appear as carbuncular swellings, which, when opened, heal quickly.

MR. LAWSON TAIT, of Birmingham, thought the calculus, as found by Dr. Fenwick, should be cut, to remove an element of doubt as to whether it was made up of cholesterin, and therefore hepatic in origin. He thinks that no case should be allowed to run for any length of time after feces have been discovered mixed with the pus, and advises immediate opening of the abdomen, that the source of trouble may be found and removed. He discountenances strongly the traditional fear of any interference with the peritoneum.

DR. FENWICK in reply, agreed with Mr. Lawson Tait that we should allow no patient to exist in such a condition when feces have been noticed. He said that in his case no feces were noticed till within a few days of the operation.

DR. SULLIVAN, of Kingston, asked Mr. Tait by what means could we tell whether an operation was necessary or not. He instanced a case of abdominal abscess in which there was much inflammation, and but little pus was obtained upon incising, and that which did come away had an intensely bad odor, as bad as though the abscess had been in the rectal region.

MR. LAWSON TAIT, in reply, said we could only find out by going in to see! He advised the application of the ordinary surgical rule, viz., open the abscess, as though it were in the arm or the thigh.

DR. SHEPHERD, of Montreal, read the next paper, on

LIGATION OF THE ANTERIOR TIBIAL ARTERY IN A CASE OF COMPOUND FRACTURE OF THE LEG.

This was the case of a French quarryman who, while at work, was struck by a stone, and had both bones of one leg broken at the junction of the upper and middle third of the leg. On admission to hospital, a compound fracture was found. The leg was put up in plaster of Paris, leaving an opening opposite the wound for purposes of dressing. The wound was dressed with iodoform. On the next day, oozing of blood occurred, requiring change of dressing. In a few days, the temperature rose, and on examining the wound, a pulsating tumor was felt. The next day, the tumor had increased; so the bandages were removed, ether administered, an Esmarch's tourniquet applied, the wound enlarged, blood-clots turned out, and Dr. Shepherd proceeded to search for the anterior tibial artery. The muscles being very much torn, the usual method of procedure was abandoned, and the interosseous membrane was reached by separating the tibialis anticus muscle from the bone. The artery was found by occasionally relaxing the tourniquet. The artery in this case was not completely torn through. After a ligature had been applied above and below the wound, a half inch of the lower end of the tibia was removed, and the ends sutured with silver wire. Drainage was used, and the wound dressed with iodoform and borated cotton. For the first few days, the discharge of pus was profuse, and several small pieces of dead bone came away, but the patient went on to recovery, and was discharged well.

This operation is rarely performed, for it is rarely called for. Dupuytren, in twenty-three years, had seven cases of diffuse aneurism due to fracture of the leg-bones; but in those cases he advised ligature of the femoral. Dr. Shepherd gave the treatment as advised by Bell, Guthrie, Hamilton, and Holmes, but he thinks that in these days we should always search for the wounded artery, and ligate it at the part torn.

DR. SULLIVAN thought the result remarkable; but fancied that, if the artery had been wholly divided, the hemorrhage might have been controlled by ordinary means.

Drs. Fulton, Giles, Girdwood, Holmes, and Proudfoot also entered into the discussion, citing cases of simple

wounds in which ligature of the artery involved became necessary.

DR. SHEPHERD, in reply, thought the discussion had wandered from the point, as all surgeons were agreed upon the advisability of cutting down upon and tying both ends of a wounded artery; but what was the best treatment in cases of wounded artery complicated by a compound fracture?

DR. GARDINER, of London, Ont., read a paper on

BURNS AND THEIR RESULTS.

He said that he had performed tracheotomy in a few cases after inhalation of hot air or steam, and has had one recovery. He finds tetanus a common complication, especially after coal-oil burns, and thinks amputation in such cases gives the only chance of success.

DR. STEWART, of Montreal, then read a paper on

THE ACTIONS AND USES OF NAPHTHALIN.

This glossy crystalline powder is a powerful preventive of decomposition in organic fluids. He kept eight ounces of urine sweet for three weeks by twenty grains. He has also kept serum of milk, pus, and infusion of pancreas pure. Vegetable and animal parasites are quickly killed by it. It does not cause irritation when applied to the unbroken skin, though it may cause smarting temporarily in wounds, but does not induce redness or swelling. Its use renders large wounds quickly antiseptic, and it does not in any way hinder free discharge. Its internal effects are but little known. It colors the urine, showing that it has been absorbed by the blood; but this is not a sign that untoward events may occur, as is the case after the use of carbolic or salicylic acids.

It is of practical use in septic chronic ulcers, and in septic burns, and in such cases was the best antiseptic that can be used. Dr. Stewart has used it in many cases of deep ulceration, and has often—in cases in which two ulcers occur on the same limb—compared its action with that of iodoform, by treating one ulcer with naphthalin and the other with iodoform; the one treated by naphthalin healed much quicker. When a wound becomes antiseptic, iodoform often interferes with the healing process, whereas naphthalin promotes it. It is more powerful, and at the same time less irritating than carbolic acid. It may be used in the form of powder, gauze, or jute. In cases of putrid ulcers, he applies the powder by dusting; and when the wound becomes antiseptic, he applies the gauze or jute till the ulcer heals.

DR. SHEPHERD agreed with Dr. Stewart that iodoform is useless in granulating wounds, and in such wounds he uses either naphthalin or balsam of Peru, but thinks the latter best, especially as a stimulant. He often uses the jute in bags of washed gauze, and applies these directly to the wound.

DR. RODDICK has used naphthalin frequently in old burns and in chronic ulcers, and has been much pleased with it. He uses it combined with boracic acid to facilitate the dusting, for it is a damp substance and difficult to powder. By using boracic acid you get a fine powder, and one that is easily applied. Dr. Roddick makes his own jute, by dusting boracic acid and naphthalin into the jute. He often sprinkles it upon the padding of fracture-splints; this, in warm weather, might be a consideration, where the patient perspires much.

DR. REEVE, of Toronto, then read a paper on

BRIEF REMARKS UPON FIFTY CASES OF TREPHINING OF THE MASTOID.

The gravity of suppurative otitis is heightened by the fact that, as a rule, the mastoid antrum, and often the other air-cells are pathologically an integral part of the middle ear (tympanum); the necessity for the operation would be markedly diminished were prompt and vigorous treatment of acute inflammation of the middle ear more generally adopted—rest, local depletion, irrigation, anodynes, vapor bath, incision of inflamed bulging drum-head, etc., would very frequently abort or curtail the disease. Chronic suppurative otitis, also, should never be neglected, but be arrested or controlled by appropriate means. The three main pathological conditions in which the operation is indicated are unrelieved suppurative periostitis of antrum, etc., ostitis with caries, and ostitis with hyperostosis and eburnation or sclerosis (condensing ostitis, Buck). Protracted delay is inadvisable. The statistics of the operation are incomplete, but eight deaths are known. Only one, however, is fairly traceable to the operation (middle fossa entered), and several are seemingly due to general or concurrent disease; in one instance the lateral sinus was opened, but patient recovered. The operation is a valuable and comparatively safe one.

MEDICAL SECTION.

DR. THORBURN, of Toronto, in the Chair.

Dr. Campbell, of Seaforth, gave an account of some cases of *Puerperal Septicæmia.*

Dr. Dupuis, of Kingston, read a paper on *Nostrums and Medical Advertising.*

Dr. R. L. MacDunnell, of Montreal, exhibited two cases of *Spastic Spinal Paralysis.*

Dr Harrison, of Selkirk, reported a *Peculiar Case of Cerebro-spinal Meningitis.*

Dr. Henry Howard, of Longue Pointe Asylum, Montreal, read a paper entitled *Materia Cogitans.*

DR. LETT, of the Homewood Retreat, Guelph, Ontario, then read a paper on

THE OPIUM HABIT.

The extent to which the opium habit, or, more properly, disease, exists, may in some degree be judged of by noting the large quantity of opium yearly imported into America. In the year 1882, it reached over three hundred thousand pounds. The methods of its habitués are varied: some smoke the drug, some snuff it, others eat the gum, or drink laudanum, paregoric, or other preparations containing it. The most common mode, however, is the employment of the hypodermatic syringe. The effects of the drug upon the human system, when habitually used, are dreadful in the extreme. When a confirmed opium-taker is deprived for any length of time of his accustomed dose, few pangs to which human flesh is heir are comparable to his. Abruptly to cut off the supply which his system craves, entails frightful tortures. The causes which induce the habit are various. Few adopt the habit voluntarily; many resort to it to

induce sleep or quiet nervous restlessness; but by far the greater number of opium-takers have had the drug administered to them for the relief of pain, either mental or physical. Such patients are entitled to our sympathy and aid; the habit in these is not a vice, but a disease, and, as such, requires to be treated.

Of the pathological changes which take place in chronic opium-poisoning, nothing has been clearly demonstrated. That there are changes has been assumed rather than ascertained by microscopical research. It does not seem to be the case that these changes are permanent; and herein consists one of the great differences between alcoholic and opium inebriety. Both, however, tend to moral obliquity; yet, while alcohol often arouses violent and dangerous emotions, those produced by opium are more placid, its victims, as a rule, being kindly disposed, but extremely cunning.

There is no known antidote to chronic opium-poisoning. What, then, is the course to be pursued in treating these cases? Shall we cut the drug off at once? No doubt, this can sometimes be done successfully; but such cases are rare. More frequently, the abrupt withdrawal of all opium is followed by the most alarming symptoms and the most acute torture, leading to suicide or to death from exhaustion. There appears to be only one method by which these cases can be successfully treated: this is to reduce very gradually the quantity taken, and, as the opium is withdrawn, to supply its place with some agent which will sustain the system and control those terrible sensations and untoward symptoms until recuperation takes place, the process of nutrition is reëstablished, and the system is able to stand alone, when both opium and its substitute can be finally withdrawn.

Before treatment is begun, it is necessary to inquire into the patient's idiosyncrasies as well as to ascertain whether he is the subject of any organic disease, which, though held in abeyance by the opium, is sure to become active when that agent is withdrawn. Inquiry must also be made as to the existence of hereditary predisposition to insanity or other serious neuropathic disorders, and lastly, in the case of females, assurance must be had that the patient is not pregnant. Abortion would be sure to take place, accompanied by alarming hemorrhage, requiring most prompt and active measures to avert a fatal issue.

For the purpose of supplying the place of opium in the manner indicated, various agents have been used. None seems to answer the purpose so well as large doses of quinine, recommended by Dr. Hughes, of St. Louis, or the best English solid extract of cannabis indica, so strongly advocated by Dr. Hubbard, of New York. During the course of treatment, other therapeutic agents are required. Valerianates and chloral will be found useful to induce sleep; compound tincture of cinchona and coca leaves are of service in depressed conditions. Hot salt-water baths can hardly be dispensed with, their power of soothing and allaying nervous irritability, equalizing the circulation, and inducing sleep, making them one of the most valuable remedies at our command. To relieve constipation, a good deal of fruit should enter into the diet. If this fail, copious enemata of castor oil and hot water will be required. During the crisis which follows the last infinitesimal dose of opium, ten-drop doses of the dilute phosphoric acid exert a wonderful influence; it cannot, however, be continued beyond five or six doses, as its tendency to irritate the stomach prohibits its further exhibition. Musk, lime-water, mustard, friction, and electricity are useful in assisting to tide the patient over the crisis, a period which lasts but twelve hours, after which all necessity or desire for opium is gone, and the danger of returning to the drug is past.

DR. R. P. HOWARD, of Montreal, read a paper on

SOME VARIETIES OF DYSPNŒA IN BRIGHT'S DISEASE,

in which the following conclusions were presented:

1. That marked dyspnœa may occur in Bright's disease, not due to gross lesions in heart, lungs, or pleura.

2. That it may be (*a*) a continuous dyspnœa, or (*b*) paroxysmal in character, resembling spasmodic asthma; and (*c*) that these types may occur in the same case, but the continued variety is more frequent than the asthmatic.

3. That these forms of dyspnœa may occur as the prominent symptom of renal disease, and their origin may escape recognition if the urine be not carefully examined.

4. That the Cheyne-Stokes' respiration is often a symptom of Bright's disease, and that it obtains in both the acute parenchymatous and in the chronic interstitial nephritis.

5. That while the Cheyne-Stokes' breathing is usually an evidence that the fatal issue is near at hand, it may occur in a chronic form, and may recur for weeks, and, perhaps, even for years.

6. That these several forms of dyspnœa are due to that defective renal elimination called uræmia.

7. That in the acute form of Bright's disease serious or fatal dyspnœa may sometimes occur in connection with effusion into the submucous membrane of the larynx—so-called œdema glottidis.

DR. GEORGE ROSS showed some

SPECIMENS OF THORACIC ANEURISM,

to call the attention of the Section to a valuable physical sign in some cases of aortic aneurism, viz., tugging at the trachea when the larynx is elevated. In the first case the sign was present in a typical manner, and the sac of the aneurism, as the specimen showed, pressed directly upon the bifurcation of the trachea. In the second case the sign was absent, and the sac was found projecting from the lower and lateral part of the arch, and not compressing to any extent the trachea, but extending into the lung and pleura.

HEART MURMUR HEARD IN THE MOUTH.

DR. GURD exhibited the patient, in whose mouth, on auscultation, a distinct systolic murmur could be heard, transmitted apparently from the chest.

Dr. Worthington, of Clinton, Ont., reported some cases of *Diabetes Insipidus, One with Exophthalmic Goitre.*

Dr. William Gardner, of Montreal, read a paper on *Common Errors in Gynecological Practice.*

Dr. Brown, of Acton Vale, Quebec, read a paper *On Impaction of the Pregnant Uterus in the Pelvis as a Cause of Abortion.*

Dr. Playter, of Ottawa, read a paper *On the Relations of the Medical Profession to the Public.*

TUESDAY, AUGUST 26TH—SECOND DAY.
GENERAL SESSION.

After the transaction of general business, MR. LAWSON TAIT, of Birmingham, delivered an address on

ABDOMINAL SURGERY.

(See THE MEDICAL NEWS of Sept. 6th, p. 253.)

It was discussed by Dr. MacMillan, of Hull, England; Drs. Hingston, Roddick, Fulton, and others.

A vote of thanks was tendered to Mr. Tait for his interesting address.

BANQUET.

In the evening the Association was entertained at the Windsor Hotel by the profession of Montreal. About two hundred guests sat down to the banquet.

SURGICAL SECTION.

This Section met at 3.30 P.M. The first paper read was by DR. MAJOR, of Montreal, on

BUCCAL BREATHING, ITS CAUSES, ETC.

Dr. Major took up in detail the causes of the pernicious habit of buccal breathing, the dangers with which this habit is fraught, and dealt fully with the treatment of each separate condition giving rise to it.

In the discussion which followed, Drs. Elsberg and Reeve took part.

DR. PROUDFOOT, of Montreal, then read a paper on

PARACENTESIS OF THE MEMBRANA TYMPANI,

calling especial attention to its value as an operation for cutting short attacks of inflammation of the middle ear.

DR. OLDRIGHT, of Toronto, then read a short paper on

MYXO-SARCOMA,

being the sequel of a paper read last year. Upon first removal the tumor was distinctly of the fibro-myxomatous variety. The tumor recurred, was removed a second time, and found to be a myxo-sarcoma.

DR. SHEPHERD, of Montreal, read a paper upon an

OBSCURE CASE OF FEMORO-POPLITEAL ANEURISM.

W. H., æt. 46, was admitted into hospital on the 31st of December, 1883, with a tumor on the lower and back part of right thigh. Had never had syphilis or rheumatism, but had been intemperate. Gave a history of having been treated in 1875 for double popliteal aneurism, which were cured. Two years afterwards a small hard lump appeared on the site of the present tumor; this had been slowly and steadily increasing, and upon admission was the size of a man's head.

It extended upwards from the popliteal space of the right thigh. It was smooth, large, and inelastic; gave rise to no pain, and there was neither pulse nor bruit to be detected. He could neither flex nor straighten the leg perfectly. The case was watched for several weeks, and he then began to complain of pain above and below the tumor. Fever followed. The tumor was slowly increasing in size, and Dr. Shepherd thought it must be a sarcoma of the parts about the bone or in the seat of the old aneurism. Ultimately amputation was performed on the 21st of February, 1884, by the circular method, through the lower third of the thigh, the stump being dressed with borated gauze and iodoform. The flaps united readily. Upon examining the tumor microscopically, it was found to consist of a mass of fibrin, but not arranged in concentric layers. The femoral artery ends above the tumor in a blind sac. Upon slitting up the popliteal it was found that the capsule of the tumor was continuous with the external coat of the artery, and thus the blood got into the tumor from below. It is difficult to explain the manner of growth of such a tumor, but Dr. Shepherd thinks the mass was in a spongy condition, so that the blood could easily permeate, and the fibrin could be slowly deposited. Dr. Shepherd then referred to the difficulty of diagnosis in such cases, no positive sign giving evidence of aneurism, and rendering it very difficult to distinguish between the non-pulsatile slowly growing aneurism and the malignant growth. Even had a diagnosis been made in this case, Dr. Shepherd thinks no other mode of treatment would have been available. To the naked eye this tumor has the appearance of a neoplasm, for the fibrin is regularly solidified throughout. There was no cavity in the tumor.

DR. GARDNER, of Montreal, reported several

CASES OF UTERINE MYOMA.

Case I.—A lady, the mother of four children, the last of which was born six years ago. The lady herself was hysterical and nervous in character, and gave a history of severe hemorrhages, nausea, and vomiting. When seen she was exceedingly blanched and much emaciated. Upon examination the uterus was found enlarged, and the sound could be passed to a depth of four inches. A tumor was detected and made out to be of the submucous variety. At the time of operation the cervix was divided deeply on both sides. the tumor was drawn down and held by the volsellum, and then removed by the serrated uterine scoop of Thomas, of New York. The after-treatment consisted of injections of hot water and the application of iodoform. On the fourth day after the operation a rigor occurred, and the temperature rose to 105°; this was controlled, however, by quinine, and after a pretty smart attack of blood-poisoning, the temperature become normal and progress toward recovery was uninterrupted. The tumor itself was about the size of a cricket-ball, very dense, and belonged to the class of true fibroids.

Case II.—A widow, aged forty-two, the mother of several children, the last having been born four years ago. The mother has never been strong since her last confinement, and when seen was very anæmic, and gave a history of unceasing menorrhagia, with nausea and vomiting. The cervix was dilated for purposes of examination, and a globular enlargement was seen. Dilatation of the cervix in such cases often arrests the hemorrhage; it did so in this case for a period of forty days, but the hemorrhage recurred, and the tumor was removed as in the first case, except that drainage was secured by a double rubber tube introduced into the cervix, the ends of which hung out of the vagina. Recovery here was uneventful. The tumor in this case was less dense than the former one, smaller, and more easily removed.

Case III.—That of a lady, aged thirty-nine, the mother of several children. She also had suffered from very profuse menstruation. In this case the tumor was detected before her last pregnancy; nothing was done at that time; she became pregnant, aborted at

the eighth month, and expelled a curiously flattened and macerated fœtus. After expulsion of the placenta terrific after-pains set in, which continued for a week, and were controlled with difficulty. At the next menstrual period the pains returned, and upon examination the tumor was detected. The tumor was removed as in the previous cases, but, as it was fully the size of a cocoanut, difficulty was experienced in diagnosticating whether it was differentiated from the uterine wall. This element of difficulty in diagnosis must always prove formidable in such cases. Since the removal of the tumor, the patient has menstruated easily and normally.

Case IV.—In this case the tumor occurred in a woman, aged fifty-two, who had had ten pregnancies, six of them having ended in abortion. She gave a history of having suffered for the past five years from exhausting hemorrhages. Upon examination the os was found dilated and protruding through it was seen the growth. The tumor in this case lay altogether in the cavity of the cervix which it had dilated, the cavity of the uterus being but little affected.

DR. STRANGE, of Toronto, complimented Dr. Gardner upon his paper, and upon the success therein detailed. In his own cases he has never incised the cervix, preferring slow but gradual dilatation. He believes thoroughly in the free irrigation of the uterus after such operations, in order to wash away the débris, and keep the parts both sweet and clean.

DR. HEYWOOD SMITH, of London, England, while congratulating Dr. Gardner upon his success, did not think such method of enucleation available or proper in all cases. He thought that in nulliparous females it would be wholly impracticable, owing to the small size of the virgin vagina; and that if incisions be made in the cervix, we should permit them to heal before proceeding to operation, for fear of septic infection. We should always suspect such tumors, when women come to us about the time of the menopause with a history of frequent and painful menstruation.

WEDNESDAY, AUGUST 27TH—THIRD DAY.

GENERAL SESSION.

The Report of the Nominating Committee was read, and the following were elected

OFFICERS FOR THE ENSUING YEAR:

President.—Dr. William Osler, of Montreal.
General Secretary.—Dr. James Stewart, of Montreal.
Treasurer.—Dr. Charles Sheard, of Toronto.
The next place of meeting.—Winnipeg, Manitoba.

DR. F. BULLER, of Montreal, then read a paper on

JEQUIRITY IN GRANULAR OPHTHALMIA.

He had used jequirity in about twenty-five cases of granular ophthalmia with pannus, in the Montreal General Hospital, during the past year, usually in both eyes, upwards of forty eyes having been submitted to this mode of treatment, the results being, on the whole, very satisfactory. For the most part, only cases of old standing, which had resisted the ordinary modes of treatment, were selected. This is probably the reason why the records show a large proportion of successful results. The solution commonly employed was made by macerating three parts, by weight, of the powdered decorticated bean in one hundred parts, by weight, of cold water. The solution was then filtered and used for each patient, in a fresh state. Wide difference in the individual susceptibility of different eyes was a very noticeable feature. In some instances, especially when there was extensive cicatricial degeneration of the conjunctiva, it was found impossible to establish the characteristic effects of the drug, *i. e.*, acute membranous ophthalmia, notwithstanding that stronger solutions were then used, sometimes as much as five or ten per cent. In ordinary cases one application of a three per cent. solution was sufficient to set up the requisite inflammatory action. Repeated applications were found to maintain a high degree of inflammation for an indefinite period, but the inflammatory process always subsided with remarkable rapidity after omitting the applications. Unquestionably, the integrity of the cornea may be jeopardized by keeping up the inflammatory process for too long a period; and, keeping this fact in view, prudence will dictate caution in using the remedy more frequently than suffices to set up the membranous ophthalmia which may be expected to ensue after one application. Repeated applications will often be required, and in this the judgment and experience of the surgeon will be the best guide.

In some very advanced cases of conjunctival degeneration (cicatricial degeneration and atrophy), in which it was found impossible to set up a membranous ophthalmia; the very moderate inflammatory reaction induced by repeated applications of the stronger solutions, was followed by a gradual and more or less complete removal of existing pannus and great improvement in vision.

The solution of jequirity is found to act best when perfectly fresh. At the end of twenty-four hours the solution is found to contain quantities of a rod-like bacillus. Stale solutions are not only more uncertain in their action, but are apt to cause eczema of the skin of the face. The solution is usually applied to the everted lids with a swab of absorbent cotten; it causes no immediate irritation, but in from three to eighteen hours the eye becomes somewhat injected, with a feeling of heat and discomfort, and there is more or less lachrymation; later the eyelids become swollen, reddened, firm to the touch, and tender; then the conjunctiva is also swollen, and presents the croupous exudation. There is a watery and flocculent, seldom purulent, secretion. The inflammatory process is much more like a diphtheritic than a purulent ophthalmia. Sometimes vast masses of false membrane are produced; absorption of trachoma granulations, and clearing of the cornea is all the more certain under such circumstances.

He was not prepared to accept the theory that the action of jequirity depends upon the development of microörganisms in the solution, for various reasons, among which may be mentioned: 1. The solution is most active when entirely free from bacteria. 2. Stale solutions filled with microörganisms are less active, and before long become inert. 3. He has not found bacteria in the solution four hours after it had been prepared for use; at this time it would already have commenced to excite inflammation if used immediately after filtration. 4. It is difficult, and often impossible to discover the supposed jequirity bacteria in the inflammatory products. 5. Jequirity ophthalmia is not con-

tagious in the sense of producing a similar inflammation.

The best results were obtained in cases of inveterate trachoma with pannus. It does not act well when the conjunctiva is succulent and swollen, with considerable hypersecretion. It should not be used in the presence of acute inflammatory conditions of the conjunctiva or cornea. To insure safety, twenty-four hours should be allowed to elapse before making a second application. It should not then be repeated if a sharp reaction has already occurred. A partial cure may sometimes be completed by a repetition of the remedy two or three weeks later, and sometimes by the use of oxide of mercury ointment.

DR. WILLIAM OSLER, of Montreal, then read a paper

ON PNEUMONIA AS AN INFECTIOUS DISEASE.

The following points were briefly referred to: (1) The existence of a considerable body of evidence to show that pneumonia occurred sometimes in epidemic form and that it *infected* certain localities, *i. e.*, houses and barracks. (2) The presence of the micrococci in the exudation, which had been abundantly proved. It is very doubtful if the coccus with a capsule, described by Friedländer, is peculiar to the disease. (3) The micrococci can be readily cultivated, and when inoculated in mice and guinea-pigs they die within a variable period, but whether the affection produced is a genuine pneumonia or only septicæmia, is not yet satisfactorily settled.

NEWS ITEMS.

SUCCESSFUL INOCULATION OF THE CHOLERA BACILLUS IN THE LOWER ANIMALS.—Dr. Bossano, of the Pharo Hospital, at Marseilles, telegraphed on September 9th that Drs. Reitsch and Ricati had just informed him that several animals which they had inoculated with Dr. Koch's microbes had died with choleraic symptoms —results which Dr. Koch had failed to obtain.

THE CARTWRIGHT PRIZE OF THE ALUMNI ASSOCIATION OF THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.—An award of this prize, which amounts to $500, will be made at Commencement, 1885, and essays in competition must be forwarded to the Prize Committee, of which Dr. Amidon, No. 18 West Twenty-first St., New York, is Chairman, before April 1, 1885. This prize is open to the competition of alumni of *any* medical college, and will be awarded to the best medical essay upon any subject the writer may select. Competing essays must be marked with a device and accompanied by a sealed envelope similarly marked, containing the name and address of the author.

BAD PLUMBING IN BELLEVUE HOSPITAL, NEW YORK.—The Board of Health three months ago was requested to examine the plumbing in Bellevue Hospital, a death there having been attributed to sewer gas poisoning. The engineer, on June 23d, reported that sewer gas escaped into the rooms occupied by nurses and physicians. He recommended that the waste pipes leading from those rooms should be ventilated and trapped. This week the Board received another report from him stating that he made another inspection on August 12th, and found that the sewer gas still escaped. No steps had been taken to improve the plumbing, although a proper notice had been sent to the Commissioners of Charities and Correction. It was said that the Commissioners could not make the needed repairs on account of lack of funds for such purposes.

THE MISSISSIPPI VALLEY MEDICAL SOCIETY will hold its tenth annual meeting at Springfield, Illinois, on Tuesday, September 23d, and the three following days.

PROF. BRAUN, of Heidelberg, has been called to the Chair of Surgery in the University of Jena.

PROF. HERMANN, of Zurich, will take the Chair of Physiology at Königsberg, rendered vacant by the resignation of Prof. von Wittich.

PROF. L. MAUTHNER is mentioned as the probable successor to the late Prof. Jäger as Professor of Ophthalmology in Vienna.

MICROBE.—The word "microbe," now so commonly used, was coined by M. Charles Sédillot, of Strasbourg, in February, 1878, in a paper which he read on the application of M. Pasteur's discoveries to surgery. Coming from the Greek words μικρος, small, and βιος life, it aptly describes the thing intended. In replying to M. Sédillot, M. Pasteur used the word twice, and scientific men have since generally adopted it.

NEW MEDICAL JOURNAL.—The first number of the *Internationales Centralblatt für Laryngologie, Rhinologie, and verwandten Wissenschaften*, has recently appeared. It is a monthly, containing a *résumé* of all the articles, brochures, or books on diseases of the larynx, nose, and allied organs. The American collaborateur is Dr. George M. Lefferts, of New York. It is published by Hirschwald, of Berlin.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM SEPTEMBER 9 TO SEPTEMBER 15, 1884.

GREENLEAF, CHARLES R., *Major and Surgeon.*—To conduct a detachment of recruits to the Department of the Columbia, and upon completion of this duty rejoin his station, Columbus Barracks, Ohio.—*S. O. 210, A. G. O.*, September 6, 1884.

GORGAS, W. C., *First Lieutenant and Assistant Surgeon.*—Assigned to duty at Fort Randall, Dakota Territory.—*S. O. 98, Department of Dakota*, September 5, 1884.

MACAULEY, C. N. B., *First Lieutenant and Assistant Surgeon.*—Assigned to duty at Fort Sisseton, Dakota Territory.—*S. O. 99, Department of Dakota*, September 6, 1884.

EGAN, P. R., *First Lieutenant and Assistant Surgeon.*—When relieved by Assistant Surgeon Fisher, to report at Fort Lowell, Arizona Territory, for duty as Post Surgeon.—*S. O. 82, Department of Arizona*, September 2, 1884.

FISHER, W. W. R,, *First Lieutenant and Assistant Surgeon.*—Assigned to duty at Fort Apache, Arizona Territory, relieving Assistant Surgeon Egan.—*S. O. 82, C. S., Department of Arizona.*

EWING, CHARLES B., *First Lieutenant and Assistant Surgeon.*—Assigned to duty, as Post Surgeon, at Fort Stanton, New Mexico.—*S. O. 177, Department of the Missouri*, September 6, 1884.

MCCAW, W. D., *First Lieutenant and Assistant Surgeon.*—(Recently appointed.) To report in person to the Commanding General, Department of the Missouri, for assignment to duty.—*S. O. 209, A. G. O.*, September 5, 1884.